

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09869

09908

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Edwards</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Charleston S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>John J. Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Teasdale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>Wm. B. Adams</u>		Address <u>7818 Ballston Rd #4</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>50</u> , to <u>Sept 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 17</u> , 19 <u>59</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		DATE SIGNED <u>9/17/59</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson Inc</u>		ADDRESS <u>1050 York Rd. Towson</u>	
24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637
TEL: 773-936-5000
FAX: 773-936-5001
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09909

CERTIFICATE OF DEATH

09870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>52</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>416 Oak Forest Ave.</u>				d. STREET ADDRESS <u>205 Garden Ridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>DONZELLA</u> Last <u>ALT</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10,</u> Year <u>59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 11, 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Retired - self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry W. Vogt</u>				14. MOTHER'S MAIDEN NAME <u>Annie Romoser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Russell Conklin - 416 Oak Forest Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis to Liver</u> <u>153.8</u> DUE TO <u>from Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>21 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>49</u> to <u>9/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>59</u> , and that death occurred at <u>2 A</u> .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin E. Singewald</u> M.D.				ADDRESS (Street, city or town, state) <u>11 E. Chase St Baltimore Md</u>		DATE SIGNED <u>9/10/59</u>	
PHYSICIAN'S NAME (Type) <u>MARTIN E. SINGEWALD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Siskner & Sons - Baltimore</u>				ADDRESS 		24a. REC'D BY REGISTRAR <u>SEP 11 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Huns</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

00250

Reg. No. 10

00000

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		Jan 1, 1920		Jan 15, 1965		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of funeral home		18. Name of cemetery		19. Name of burial place		20. Name of next of kin	
Teacher		High School		Married		123 Main St		ABC Corp		Dr. Smith		XYZ Funeral Home		Greenwood Cemetery		Section 1, Lot 10		Mrs. Jane Doe	
21. Name of informant		22. Relationship to deceased		23. Informant's address		24. Informant's phone		25. Informant's signature		26. Registrar's signature		27. Registrar's seal		28. Registrar's stamp		29. Registrar's date		30. Registrar's time	
John Doe		Son		123 Main St		555-1234		[Signature]		[Signature]		[Seal]		[Stamp]		Jan 15, 1965		10:00 AM	

RECEIVED
JAN 16 1965
BALTIMORE, MD

FILED
JAN 16 1965
BALTIMORE, MD

09871

Reg. Dist. No.

1. PLACE OF DEATH State Training School a. COUNTY Baltimore MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland										c. LENGTH OF STAY IN 1b 1 1/2 months										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School										d. STREET ADDRESS 2907 Spellman Road										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Harriet Mary Anderson										4. DATE OF DEATH Month 9 Day 10 Year 59																													
5. SEX Female										6. COLOR OR RACE Negro										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																			
8. DATE OF BIRTH 9/24/58										9. AGE (In years last birthday) 11 yrs.										IF UNDER 1 YEAR Months 11 Days 14																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country) Maryland (BALTO?)										12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Paul Anderson										14. MOTHER'S MAIDEN NAME Mary Anderson																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no										16. SOCIAL SECURITY NO. no										INFORMANT Rosewood Records										Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500X Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Bronchitis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 9/2/59 9/2/59																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Non-communicative Hydrocephalus, congenital - birth										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 9/2/59, 19, to 9/10/59, 19, that I last saw the deceased alive on 9/10/59, 19, and that death occurred at 8:00aM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harry G. Butler, M.D. Rosewood Training School 9/10/59 PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. Owings Mills, Maryland																																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9-14-59										22b. DATE THEREOF 9-14-59										22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cm										22d. LOCATION (City, town, or county) (State) A.D.C. Md									
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson										ADDRESS 3000										24a. REC'D BY REGISTRAR DATE SEP 21 1959										24b. REGISTRAR'S SIGNATURE Giles & Howard									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
IS 15
9/58

1887

CERTIFICATE OF DEATH

1887

State of New York
County of Albany
City of Albany
I, the undersigned, being a duly qualified physician, do hereby certify that on the 1st day of January, 1887, at the City of Albany, in the County of Albany, State of New York, died a person named John Smith, of the County of Albany, State of New York, who was born on the 1st day of January, 1850, at the City of Albany, in the County of Albany, State of New York, and who was a resident of the City of Albany, in the County of Albany, State of New York, at the time of his death.

Witness my hand and the seal of my office this 1st day of January, 1887.
J. H. Smith, M.D.
Physician

1887

1887

1887

1887

Non-Resident of this State

1887

1887

1887

1887

1887

1887

1887

Reg. Dist. No.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1901

Name of deceased		John Doe	
Age		45 years	
Sex		Male	
Race		White	
Marital status		Married	
Occupation		Farmer	
Cause of death		Heart disease	
Date of death		Jan 15, 1901	
Place of death		Home	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09913

CERTIFICATE OF DEATH

Reg. Dist. No.

09874

1. PLACE OF DEATH Rosewood State Training School o. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland			c. LENGTH OF STAY IN 1b 7 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School			d. STREET ADDRESS 311 Locust Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Lawrence Middle LaMonaco Last Armiger			4. DATE OF DEATH Month 9 Day 8 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/47	9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Paul Armiger			14. MOTHER'S MAIDEN NAME Frances LaMonaco			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. -----			
INFORMANT Rosewood Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Em pyema of right pleural cavity 491X DUE TO (b) bilateral bronchopneumonia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:15 PM , from the causes and on the date stated above.						
ACTUAL SIGNATURE Peter W. Rieckert			ADDRESS (Street, city or town, state) 4307 Mansfield Ave Baltimore 14, Md.			
DATE SIGNED 9-10-59			DATE SIGNED SEP 10 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-10-59			
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck			24a. REC'D BY REGISTRAR 5305 Harford Rd.			
24b. REGISTRAR'S SIGNATURE Arthur L. Huns						

CERTIFICATE OF DEATH

1901

County of ... State of ...

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Handwritten signature and text, likely a medical certificate or statement.

X

Handwritten text at the bottom of the page, possibly a date or location.

Handwritten text at the bottom right of the page.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09873	
CONRAD A. ATKINSON										09912	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Caton. 28</i>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10 Park Drive</i>					d. STREET ADDRESS <i>110 Park Drive</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Conrad A. Atkinson</i> First Middle Last					4. DATE OF DEATH <i>Sept. 5</i> 19 <i>59</i> Month Day Year						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/13/83</i>		9. AGE (In years lost birth day) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Catholic rev.</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>newspaper</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles Atkinson</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Ellis</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service					16. SOCIAL SECURITY NO.		INFORMANT <i>Margaret Atkinson</i> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis C.V.D.</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>instant</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>3/5</i> , 19 <i>58</i> , to <i>9/5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/5</i> , 19 <i>59</i> , and that death occurred at <i>1 P</i> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>J. C. Pounce</i>					ADDRESS (Street, city or town, state) <i>3325 Fredericka</i> DATE SIGNED						
PHYSICIAN'S NAME (Type) <i>J. C. Pounce</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					22b. DATE THEREOF <i>9/8/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>			22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Stabb & Son</i> ADDRESS <i>28</i>					24a. REC'D BY REGISTRAR <i>SEP 9 '59</i> DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>				

00223

RECEIVED BY THE DIRECTOR OF THE BUREAU OF LANDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09914

CERTIFICATE OF DEATH

Reg. Dist. No.

09875

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LLOYD Middle M. Last BARGER		4. DATE OF DEATH Month September Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1898
9. AGE (In years lost birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY VA RO US.Govt.	
11. BIRTHPLACE (State or foreign country) Kansas City, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert H. Barger		14. MOTHER'S MAIDEN NAME Mary Inez Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clin. Records, VAH, Balto, MD, Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 ACUTE MYOCARDIAL INFARCTION DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 10 1959 to September 16 1959 , and that death occurred at 6:25A AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO 18, MD. FORT HOWARD DIV. DATE SIGNED 9/16/59 ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTO 18, MD. FORT HOWARD DIV. DATE SIGNED 9/16/59 PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, FORT HOWARD, DIVISION DATE SIGNED 9/16/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept. 21/59	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest		22d. LOCATION (City, town, or county) (State) Fulton, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson Md.		24a. REC'D BY REGISTRAR DATE SEP 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Hana			

CERTIFICATE OF DEATH

Deceased

Age (Years)

Sex

Color

Place of Birth

Place of Death

Married

Single

Date of Death

Time of Death

Place of Death

Cause of Death

Signature

Physician

Medical Examiner

Witness

Signature

Official Record

Recorded

VA

Filed

Index

John W. Johnston

Removal

Revised

09915

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 mo?</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			
f. STREET ADDRESS <u>911 Middlesex Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry W. Barrett Sr.</u>				4. DATE OF DEATH <u>9</u> Month <u>23</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>✓</u>			
17. INFORMANT <u>Mrs Edward R. Krickham</u> Address <u>2112 Ave Parkley</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis with Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>② Hemiplegic left old</u> (c) <u>③ Amputation Mid thigh left.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>✓</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/23/59</u> to <u>9/23/59</u> , that I last saw the deceased alive on <u>9/23/59</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W E McGrath</u> M.D.				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 md</u> DATE SIGNED <u>9/24/59</u>			
PHYSICIAN'S NAME (Type) <u>W E McGrath</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/26/59</u>		<u>Manhasset Cem.</u>		<u>Potomac Highway md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>9 Hoelous St.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09902
ITEMS - #1, 2, & 4 - Please Call 9/14/59 ms.
CERTIFICATE OF DEATH

09877
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Arbitus	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS Arbitus 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1013 Linden Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Nelson Last Barry		4. DATE OF DEATH Month September Day 10 Year 1959	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME John J. Barry		14. MOTHER'S MAIDEN NAME Margaret Cavanaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W. I		16. SOCIAL SECURITY NO. 705 12-5914	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchiogenic Carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 57 , to 9/10 , 19 59 , that I last saw the deceased alive on 9/10 , 19 59 , and that death occurred at 8:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1305 Francis Avenue Balto. 27, Md. DATE SIGNED SEP 14 59			
ACTUAL SIGNATURE James Frederick, Md. M.D.			
PHYSICIAN'S NAME (Type) James Frederick, Md. 1305 Francis Avenue Balto. 27, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR SEP 14 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur A. Kins			

LEWIS H. HUGHES 1107 WILKINS AVENUE

BOSTON 10100 BALTIMORE NATIONAL CO. BALTIMORE, MARYLAND

JAMES FRANKLIN, JR. 1305 FRANKLIN AVENUE BALTIMORE, MD.

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1700 1700 1700 1700 1700 1700 1700 1700 1700 1700

JOHN J. BARRY HARRINGTON CAVANAGH

RESIDE D & O R.R. CO. MARYLAND U. S. A.

MALE WHITE X Sept. 8, 1897 62

JOHN WILSON BERRY

1013 MADISON AVENUE 1013 LINDEN AVENUE

XXXX BALTIMORE

BALTIMORE

BALTIMORE

MARYLAND

BALTIMORE

09916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Esther Keckner Barshinger				4. DATE OF DEATH Month Day Year 9-12-59 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator				10b. KIND OF BUSINESS OR INDUSTRY Tel. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Adam Keckner				14. MOTHER'S MAIDEN NAME Sarah Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0324		17. INFORMANT Mrs. Edna Burke,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gen. Arteriosclerosis DUE TO (c) Rheumatic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 5 yrs ? Childhood							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 59				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1938 to 9-12-59 , that I last saw the deceased alive on 9-12-59 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3105 N. Charles St. Baltimore, 18. 948 DATE SIGNED ACTUAL SIGNATURE Robert H. Siver M.D. PHYSICIAN'S NAME (Type) Robert H. Siver							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-59		22c. NAME OF CEMETERY OR CREMATORY Lessop Methodist		22d. LOCATION (City, town, or county) (State) Sparks, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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STANDARD SERVICE, NEW YORK, N.Y.

7-17-52

George Kecheloff

Spokane, W.I.

Robert E. Jager

Mr. John Smith, 805

John Kecheloff

John Kecheloff

Telephone Operator Tel. Co.

Maryland

White, 1-1-1986

Robert Kecheloff

7-17-52

John No.

John No.

Cookseyville

Life

Cookseyville

Initiator

Maryland

Spokane

BATHGATE 09917 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>2 WK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shadybrook Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Genevieve Bathgate</u> First Middle Last				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/98</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Amos Bathgate</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Parnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>099-111880-151</u>			
17. INFORMANT <u>Dr. Driscoll Presche</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X Branchial asthma + emphysema</u> DUE TO (b) <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>241X</u> DUE TO (b) <u>241X</u> DUE TO (c) <u>241X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-9-59</u> , 19 <u>59</u> , to <u>9-9-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-9-59</u> , 19 <u>59</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Nesbitt Jr.</u>				ADDRESS (Street, city or town, state) <u>1118 St Paul St Baltimore 2, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT JR.</u>				DATE SIGNED <u>9-9-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olmest</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Craft + Son</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur G. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

1000

1000

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CERTIFICATE OF DEATH

Reg. Dist. No.

09918

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 24 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD LEROY BAUMGARDNER		4. DATE OF DEATH Month September Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1918
9. AGE (In years for birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Owner of Shop	
11. BIRTHPLACE (State or foreign country) Hanover, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Baumgardner		14. MOTHER'S MAIDEN NAME Martha J. Barnhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 207 -03-7321	
17. INFORMANT Clin. Records, VAH, Balto. 18, Md., Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOID, LIVER 211X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. XX METASTATIC CARCINOID, MESENTERIC AND RETRO- PERITONEAL LYMPH NODES (c) PULMONARY CONGESTION AND EDEMA INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. (Operation) Surgical absence, lower colon & rectum. 2. Colostomy (Operation)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 21, 1959 , to September 14, 1959 , and that death occurred at 6:30 A. M. from the causes and on the date stated above. GIVE ON VAH, Baltimore, Md. Fort Howard Div. 9/14/59			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, Baltimore, Md. Fort Howard Div. 9/14/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE 9/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-17-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hanover, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Son		24a. REC'D BY REGISTRAR DATE SEP 18 '59	
ADDRESS Broadway St. Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00012

Pennsylvania

Hanover

21 days

First Death

July 21, 1918

Hanover, Pennsylvania

County of York

Martha J. Bennett

Martha J. Bennett

PREVIOUSLY CALLED: LIVER

REMARKS: DARK, BROWN, KIDNEY, AT 2:30 P.M.

REMARKS: WHITE, WHITE, WHITE

REMARKS: WHITE, WHITE, WHITE

1. (Specimen) - 1st of specimen, lower colon, section, 2. (Specimen)

(Specimen)

V.A. Baltimore, Md. Post Office Div. 2/1/17

V.A. Baltimore, Md. Post Office Div. 2/1/17

Hanover, Pennsylvania

County of York

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31 X
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G249 9-28-59 et
09919
CERTIFICATE OF DEATH

09881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN 1b 83 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT T. Middle W. Last BEACH		4. DATE OF DEATH Month September 21 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert W. Beach, Sr.		14. MOTHER'S MAIDEN NAME Mary Cunningham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Frances M. Beach		Address Westminister, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to Sept 21 , 19 59 , that I last saw the deceased alive on Sept 20 , 19 59 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pikesville 8 Md. DATE SIGNED Palmer T. Williams M.D.			
ACTUAL SIGNATURE Palmer T. Williams		PHYSICIAN'S NAME (Type) Dr. Palmer Williams	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/59	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		ADDRESS 1900 Eutaw Place	
24a. REC'D BY REGISTRAR SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

09893

Item 9 FilmG248 9-18-59 et

VS. A15ME(S)
SM 9/55

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53</u> (22)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1858 E Battle Grove Ave</u>		d. STREET ADDRESS <u>1858 E Battle Grove Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Diana</u> Middle <u>Lynne</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1952</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Edna Louise Ritchie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emanuel Bennett</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma, left kidney</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>14 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> to <u>Sept. 27, 1959</u> , that I last saw the deceased alive on <u>Nov.</u> , <u>1958</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D. <u>6077 Harford Rd.</u> <u>9-27-59</u> PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u> <u>Balto. 14, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Brandywine, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05884

09921

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7925 Berk Lane				d. STREET ADDRESS 7925 Berk Lane			
3. NAME OF DECEASED (Type or print) SADIE				4. DATE OF DEATH 9 20 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 9, 1904	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		10b. KIND OF BUSINESS OR INDUSTRY Waverly Press		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Godfrey Berk				14. MOTHER'S MAIDEN NAME Theresa Madl			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-1604		17. INFORMANT Catherine Grant		Address 5918 Medow Rd. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 420.1 Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE R. Fisher M.D. M.D. DATE SIGNED 9-21-59 EXAMINER'S NAME (Type) Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Zion Evan. Lutheran		22d. LOCATION (City, town, or country) (State) Stemmers Run, Md.	
23. FUNERAL DIRECTOR Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR SEP 23 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

FOR THE
HONORABLE

1

TO THE HONORABLE
COMMISSIONER OF THE
LAND OFFICE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10000

SEP 22 20

09922

CERTIFICATE OF DEATH

19932

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Blake, Miss Lucy Groverman</i>		2. DATE OF DEATH <i>Sept 29 1959</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>615 Chestnut Ave</i> B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <i>Towson H. Md.</i> <i>Aged Nurse Women's Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>3V01.4</i> D. STREET ADDRESS (If rural, give location) <i>1215 Eutaw Place</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>		8. DATE OF BIRTH <i>Nov. 22, 1868</i>	
9. AGE (In years last birthday) <i>90</i>		10. MONTHS <i>10</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert County, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Blake</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Blake</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Daisy E. Sammons</i>		ADDRESS <i>615 Chestnut</i>	

18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypostatic Pneumonia</i>		CAUSE OF DEATH <i>Hypostatic Pneumonia</i>	INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerotic Cardiovascular</i>		DUE TO <i>Disin</i>	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> 19 <i>51</i> to <i>Sept 29</i> 19 <i>59</i> , that (I) (we) last saw the deceased alive on <i>Sept 27</i> 19 <i>59</i> , and that death occurred at <i>5:05 P</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Marland E. Day</i>		23B. ADDRESS <i>4-E-33rd St Baltis</i>	23C. DATE SIGNED <i>Sept 29, 1959</i>
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	24B. DATE <i>9-30-59</i>	24C. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Calvert County, Maryland</i>
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR <i>William Cook, Inc., 1217 St. Paul Street</i>	
REGISTRAR'S SIGNATURE <i>William Cook</i>		ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09885

09923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13yr3mth9dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
3. NAME OF DECEASED (Type or print) First Minnie Middle Block Last Block		4. DATE OF DEATH Month September Day 4 Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1889
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Abraham sheer		14. MOTHER'S MAIDEN NAME Yetta Ania	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956 to Sept. 4, 1959 , that I last saw the deceased alive on Sept. 4, 1959 , and that death occurred at 12:30a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-4-59	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-6-1959	22c. NAME OF CEMETERY OR CREMATORY Orosedale	22d. LOCATION (City, town, or county) (State) Balto Md.
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS 2100 Eutaw Place		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09924

CERTIFICATE OF DEATH

Reg. Dist. No.

09886

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House in The Pines		d. STREET ADDRESS Marlborough Apt Eutaw Place & Wilson Street	
3. NAME OF DECEASED (Type or print) Hattie First T Middle Blumberg Last		4. DATE OF DEATH Sept 26 1959 Month Sept Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR 7 Months 12 Days	11. IF UNDER 24 HRS. 12 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Tannebaum		14. MOTHER'S MAIDEN NAME Hannah Rider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Marlborough Apt Simon Blumberg, Eutaw Pl & Wilson St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Gen. ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. ASCVD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1959 , to Sept. 26 1959 , that I last saw the deceased alive on Sept 26 1959 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel Bakal M.D.		ADDRESS (Street, city or town, state) 3600 Lochearn Dr. Balto. 7, Md	
PHYSICIAN'S NAME (Type) DANIEL BAKAL, M.D.		DATE SIGNED Sept 26, 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-28-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cem	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin ADDRESS 1902 Eutaw Place		24a. REC'D BY REGISTRAR SEP 29 59	24b. REGISTRAR'S SIGNATURE Arthur A. Thompson

CERTIFICATE OF DEATH

DECEASED NAME DATE OF BIRTH SEX RACE PLACE OF BIRTH DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN SIGNATURE OF CLERK OFFICIAL USE REGISTERED INDEXED FILED DATE TIME PLACE CAUSE MANNER SIGNATURE OFFICIAL USE REGISTERED INDEXED FILED DATE TIME PLACE CAUSE MANNER SIGNATURE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09887

09925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland 02X-2	
c. LENGTH OF STAY IN 1b 3mthl1dys		d. STREET ADDRESS 305 Third Avenue - S. E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle Henrietta Last Boessel		4. DATE OF DEATH Month Sept. Day 12 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1875
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 12 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Henry Matzen		14. MOTHER'S MAIDEN NAME Unknown Katherine Giles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) WWWW		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERAL DEBILITY DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 21 , 19 59 , to SEPT. 12 , 19 59 , that I last saw the deceased alive on SEPT. 12 , 19 59 , and that death occurred at 7:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Patrick K. Yip		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) PATRICK K. YIP		DATE SIGNED Sept. 12, 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15 Sept, 1959	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton		ADDRESS Glen Burnie, Md.	
24a. REC'D BY REGISTRAR SEP 15 '59		24b. REGISTRAR'S SIGNATURE C. L. Hines	

09926
CERTIFICATE OF DEATH

Reg. Dist. No.

09888

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1306 James Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Borgealt Last Borgealt		4. DATE OF DEATH Month September Day 22 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work at Home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Borgealt		14. MOTHER'S MAIDEN NAME Carrie Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 30 , 19 59 , to Sept. 22 , 19 59 , that I last saw the deceased alive on Sept. 22 , 19 59 , and that death occurred at 1:25 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-22-59			
ACTUAL SIGNATURE Stella Wachler		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/24/59	Not Olivet Cem.	2930 Frederick Ave
23. FUNERAL DIRECTOR'S SIGNATURE John J. Bowman		24a. REC'D BY REGISTRAR Hollins St.	24b. REGISTRAR'S SIGNATURE Arthur E. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09894

CERTIFICATE OF DEATH

09889

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. LENGTH OF STAY IN 1b 53 Dundalk (22)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6825 Dunhill Road				d. STREET ADDRESS 6825 Dunhill Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ERCEL Middle VIRGINIA Last BOSLEY				4. DATE OF DEATH Month September Day 14 Year 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1891	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Hitt				14. MOTHER'S MAIDEN NAME Ella Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Garnet Staats- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension + A-S-C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 15 yk	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1959 to Sept. 14, 1959 , that I last saw the deceased alive on Sept. 1, 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6008 Mornington Road DATE SIGNED 9/14/59 ACTUAL SIGNATURE M B Davis M.D. PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.				24a. REC'D BY REGISTRAR DATE SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capoea papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09927

CERTIFICATE OF DEATH

Reg. Dist. No.

09890

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 511 N. Mount Street (17) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last BOWEN		4. DATE OF DEATH Month September Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1890
9. AGE (In years lost birthday) 68		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Bakery Truck	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Bowen		14. MOTHER'S MAIDEN NAME Ella Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 212-14-2039	
17. INFORMANT Clin. Records, VAH Baltimore, Md., Ft. Howard Div.		Address Clin. Records, VAH Baltimore, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION 522X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMPHYSEMA (c) ARTERIOSCLEROSIS, MARKED, GENERALIZED THROMBOSIS, RT. FEMORAL ARTERY WITH GANGRENE RIGHT LOWER EXTREMITY		INTERVAL BETWEEN ONSET AND DEATH Recent Unknown Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 PNONEPHROSIS, LEFT KIDNEY. EMACIATION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that John W. Crawford attended the deceased from September 17 19 59 , to September 24 59 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, BALTIMORE, MD., FT. HOWARD DIV.	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 9/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE A. Halstead		ADDRESS ADOLPHUS HALSTEAD, 518 Druid Hill Ave., Balto., Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE SEP 28 '59			

ADOLPHUS HALSTEAD, 518 Druid Hill Ave., Balto., Md.

Belmont

For: Howard

Volunteers Administration Hospital

WILLIAM

State

Chambers

Joseph Bowen

Yes

W. L. 1

212-14-6039

W. L. 1

W. L. 1

W. L. 1

W. L. 1

W. L. 1

W. L. 1

W. L. 1

W. L. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09928

CERTIFICATE OF DEATH

Reg. Dist. No.

09891

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1440 Providence Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle N.S. Last BRITTON		4. DATE OF DEATH Month Sept. Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1906
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair man		10b. KIND OF BUSINESS OR INDUSTRY Black and Decker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward T. Britton, Sr.		14. MOTHER'S MAIDEN NAME Henrietta Morfoot	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-9820	
17. INFORMANT Hilda S. Britton		Address 1440 Providence Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEUKEMIA (LYMPHOID) 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 8, 1959 , to SEPT. 26, 1959 , that I last saw the deceased alive on SEPT. 24, 1959 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. C. Siwinski		ADDRESS (Street, city or town, state) 17 W. PENNA. AVE. BALDOWINE, MD.	
PHYSICIAN'S NAME (Type) T. C. SIWINSKI		DATE SIGNED 9/28/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59	22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens Timonium, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		24a. REC'D BY REGISTRAR SEP 29 '59	
ADDRESS 1050 York Rd. Towson		24b. REGISTRAR'S SIGNATURE Arthur J. Frank	

00801

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1922

Name of Deceased		Sex		Age	
John - [illegible]		Male		[illegible]	
Date of Death		Place of Death		Cause of Death	
[illegible]		[illegible]		[illegible]	
Occupation		Usual Residence		Place of Burial	
[illegible]		[illegible]		[illegible]	
Manner of Death		Medical Attendant		Physician	
[illegible]		[illegible]		[illegible]	
Signature of Registrar		Signature of Physician		Signature of Medical Examiner	
[illegible]		[illegible]		[illegible]	
Date of Registration		Place of Registration		County	
[illegible]		[illegible]		[illegible]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09929

CERTIFICATE OF DEATH

Reg. Dist. No.

09892

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 35 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson 4		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 303 W. Penn. Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Nicholas Britton		4. DATE OF DEATH Month Day Year 9-12-59 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1869
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) supertendent		10b. KIND OF BUSINESS OR INDUSTRY cloth mill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard M. Britton		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
INFORMANT Miss Sheldon Frantz		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOCLEROSIS 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FRACTURE NECK OF RIGHT FEMUR - JAN 3, 1959			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL DOWN STAIRS AT HOME	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1 3 59 p. m. 7		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) TOWSON 4 MD.	
21. I certify that I attended the deceased from JAN 3 , 1959, to SEPT 12 , 1959, that I last saw the deceased alive on SEPT 7 , 1959, and that death occurred at 720 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. C. Siwinski		ADDRESS (Street, city or town, state) 17 W. PENNA. BL. BAL.	
PHYSICIAN'S NAME (Type) T. C. SIWINSKI		DATE SIGNED 9/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-59	
22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09930

CERTIFICATE OF DEATH

09893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in lines</u>		d. STREET ADDRESS <u>4205 Fords Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Brodnick</u> Middle Last		4. DATE OF DEATH <u>9-21-1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03</u> yrs.
9. AGE (In years last birthday) <u>03</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Block maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Brodnick</u>		14. MOTHER'S MAIDEN NAME <u>Elyzabeth Brodnick - Same</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Elyzabeth Brodnick - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial Discompensation</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Generalized atherosclerosis</u> DUE TO <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>103 days</u> <u>103 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-15-1959</u> to <u>9-21-1959</u> , that I last saw the deceased alive on <u>9-21-1959</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>9-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eutaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09894

09931
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 27 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle BROWN Last BROWN		4. DATE OF DEATH Month September Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 6, 1887
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Brown		14. MOTHER'S MAIDEN NAME Mary Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 218-09-6402-	
17. INFORMANT Clin. Rec. VAH. Balto 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH 420.0 RIGHT CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE AND CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 5 , 19 59 , to September 1 19 59 and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD., FORT HOWARD DIV. DATE SIGNED 9/2/59 ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTO. 18, MD., FORT HOWARD DIV. 9/2/59 PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD., FORT HOWARD DIV. 9/2/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-59	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens 1501 E. Fort Ave. Baltimore, Md. Charles F. Diehl Successor		24a. REC'D BY REGISTRAR DATE SEP 11 '59	24b. REGISTRAR'S SIGNATURE C. F. Diehl

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Deceased		Burial	
Name: Charles I. Stevens		Place: Holy Cross Cemetery	
Age: 1201 N. York Ave.		County: Anne Arundel County, Maryland	
Sex: Male		Race: White	
Date of Birth: November 6, 1877		Date of Death: September 1, 1939	
Place of Birth: U. S. A.		Cause of Death: CHRONIC PHLEBITIS	
Occupation: Self-employed		Manner of Death: Accident	
Residence: 103 Norman Road		Hospital: St. Johns Hospital	
Physician: Dr. J. H. Brown		Coroner: Dr. J. H. Brown	
Witness: Yes		Burial: Yes	
Remarks: CHRONIC PHLEBITIS		Remarks: CHRONIC PHLEBITIS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09932

09895

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JERRY Middle --- Last BRYANT				4. DATE OF DEATH Month September Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Grassy Creek, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Bryant				14. MOTHER'S MAIDEN NAME Phoebe MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address VAH, Balto 18, Md. Fort Howard Div. Clin. Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> attended the deceased from Sept. 17 , 19 59 to Sept. 20 , 19 59 , and that death occurred at 8:00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David A. Oursler				ADDRESS (Street, city or town, state) VAH, BALTO 18 MD, FORT HOWARD DIV. 9/21/59			
PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elliott Funeral Home ADDRESS 1129 N. Caroline St. Balto. Md.				24a. REC'D BY REGISTRAR DATE SEP 24 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Kraus	

References

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09933

CERTIFICATE OF DEATH

Reg. Dist. No.

09896

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 95 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle B. Last BRYANT		4. DATE OF DEATH Month September Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1895
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4	11. IF UNDER 24 HRS. Hours 4 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vehicle Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Nokomis, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Bryant		14. MOTHER'S MAIDEN NAME Marie Burroughs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 215-18-9160	
17. INFORMANT Clin. Rec., VAH Balto 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT SIDE OF NECK 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMORRHAGE OF CARCINOMATOSIS SITE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from June 3 , 19 59 , to September 6 , 19 59 , and that death occurred at 7:45 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		ADDRESS (Street, city or town, state) M.D. VAH Balto. 18, Md., Ft. Howard Div. 9/6/59	
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.		ADDRESS VAH Balto. 18, Md., Ft. Howard Div. 9/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. 6009 Harford Rd.		24a. REC'D BY REGISTRAR SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Signal, Baltimore National

Baltimore, Md.

WALTER C. WILSON, M.D.

VAN SICK, 18, 19, 20, Howard St., 245/22

RECORDED & INDEXED

1924

June 2

Reported on 8

SPRINGFIELD, MASS.

1924

VAN SICK, 18, 19, 20, Howard St., 245/22

SPRINGFIELD, MASS.

MEMORANDUM OF RECOMMENDATION & STATE

CARDINAL OF LIT. ST. OF 1908

Mr. I

1912-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-256

09954

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

NOV 1950
FBI
RECEIVED

11/1/50

John Burns' Sons, Towson, Maryland

SEP 10 1950

Removal/Burial Sept. 27, 1950, Salisbury Cemetery, Salisbury, North Carolina

No Home 243-22-3232 Woodrow Wilson Highway, Towson, Md.

James A. Norton, Sr. Alice Adams

Attendant-Payco. Sheppard-First Hosp. S. Carolina

USA

Nov. 1, 1950

x

11/1/50

Two John Ford

Two John Ford

Tolson

Tolson

Walters

Walters

Walters

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09898

09935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Glencoe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Oaks</u>				/d. STREET ADDRESS <u>Glen Oaks</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>ELLEN</u> Middle <u>W.</u> Last <u>BUFFINGTON</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1901</u>		9. AGE (In years lost birthday) <u>58</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Watson</u>				14. MOTHER'S MAIDEN NAME <u>Eva Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Mr. Louis Buffington - 405 E. 54th St. New York</u>		Address <u>#22, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>10 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 19 59</u> to <u>Sept 18, 19 59</u> that I last saw the deceased alive on <u>September 15, 19 59</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John R. Davis</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balt. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

115204

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF

CENTRAL OFFICE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09899

Reg. Dist. No.

09895

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dundalk				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alex Buck Bullard				4. DATE OF DEATH Sept 28 / 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 22 1910	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lunch Wagon Operator				10b. KIND OF BUSINESS OR INDUSTRY North Carolina			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Lonnie Bullard				14. MOTHER'S MAIDEN NAME Azzie Willowghby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Gwen Bullard				Address 7141 Holabird Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) remal		22b. DATE THEREOF Sept 29/59		22c. NAME OF CEMETERY OR CREMATORY Meadow Brook Cem		22d. LOCATION (City, town, or county) (State) Lumbertown North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave				24a. REC'D BY REGISTRAR DATE OCT 2 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Howard	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09900

09936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X COCKEYSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>POWERS AVE</u>		d. STREET ADDRESS <u>POWERS AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATILDA M. BURTON</u>		4. DATE OF DEATH Month Day Year <u>9 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 5, 1880</u>
9. AGE (In years last birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>WONE</u>	
17. INFORMANT <u>JOSEPH BURTON-POWERS AVE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CardioVascular Disease</u> and (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>59</u> to <u>September 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>September 7</u> , 19 <u>59</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>48 Main Street</u> <u>9/8/59</u>			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		M.D. <u>48 Main Street</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel M.D.</u>		<u>Reisterstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 9/11/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Worshipful Co. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Blumenthal</u>		ADDRESS <u>1701 N. Calhoun</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09901

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 32 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VAH				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRED Middle E Last BYERS				4. DATE OF DEATH Month SEPTEMBER Day 6 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 19, 1896	
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED			
13. FATHER'S NAME MARION BYERS				14. MOTHER'S MAIDEN NAME ANNA HUNKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 220-32-0042			
17. INFORMANT CLIN REC VAH BALTIMORE MD-FORT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 201X DUE TO lying cause lost. (c) 201X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 201X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from August 5 , 19 59 , to September 6 , 19 59 , and that death occurred at 11:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 9-7-59							
ACTUAL SIGNATURE Clovis M. Snyder M.D.				M.D. VAH, Fort Howard, Maryland 9-7-59			
PHYSICIAN'S NAME (Type) Clovis M. Snyder				M.D. VAH, Fort Howard, Maryland 9-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59		22c. NAME OF CEMETERY OR CREMATORY WESTMORELAND CO. MEMORIAL PARK GREENBURG, WESTMORELAND CO.		22d. LOCATION (City, town, or county) (State) PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc., North & Pennsylvania Aves. Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE SEP 8 59			
				24b. REGISTRAR'S SIGNATURE Arthur A. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OF DEATHS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-252 11/19/59.cac.

CERTIFICATE OF DEATH

09902

09903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4308 Wilkens Ave</u>				d. STREET ADDRESS <u>4308 Wilkens Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>P.</u> Last <u>Cadden Sr.</u>				4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Belt School Board, Barton Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Patrick Cadden</u>				14. MOTHER'S MAIDEN NAME <u>Ann Stanton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dr. John J. Cadden</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>MYOCARDITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) <u>HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>FEB 1</u> , 19 <u>51</u> , to <u>SEPT 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 23</u> , 19 <u>59</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel S. Shanahan M.D.</u>				ADDRESS (Street, city or town, state) <u>1011 N CHARLES ST.</u> DATE SIGNED <u>9/24/59</u>			
PHYSICIAN'S NAME (Type) <u>DANIEL S. SHANAHAN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/26/59</u>		<u>London Park Cem.</u>		<u>3801 Frederick Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gowans Jr. Hollins St.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form 100-10

1918

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

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USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN TOWN Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 1/2 Lincoln Ave.		e. STREET ADDRESS 202 1/2 Lincoln Avenue		f. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charlotte		First Cheatham		Middle Cheatham		Last Cheatham		4. DATE OF DEATH Month September Day 28 Year 19 59	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1872		9. AGE (In years lost birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Monkton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John W. Harris		14. MOTHER'S MAIDEN NAME Julia Harris							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna Jackson		Address 202 Lincoln Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vascular Renal & Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hereford, Maryland		(County) (State)	
21. I certify that I attended the deceased from 6/4 , 19 59 , to 8/28 , 19 59 , that I last saw the deceased alive on 9/27 , 19 59 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 19 W. Seminary Ave., Lutherville, Md. DATE SIGNED 9/28/59									
ACTUAL SIGNATURE Bennett A. Stoen		PHYSICIAN'S NAME (Type) Bennett A. Stoen							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Luke Church Cemetery		22d. LOCATION (City, town, or county) Hereford, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson		ADDRESS Home Inc., 916 Penna Ave.		24a. REC'D BY REGISTRAR SEP 30 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hines			

VS A15 (4)
15M 10/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09939

CERTIFICATE OF DEATH

09904

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edmar Orchid Road Box 180				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joshua Middle G. Last Chenoweth				4. DATE OF DEATH Month Sept. Day 26 Year 19 59			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> Never married Divorced	8. DATE OF BIRTH 7/19/99		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I				16. SOCIAL SECURITY NO. None		17. INFORMANT Gladys I. Chenoweth Edmar Orchid Road Box 180 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma - lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 26, 19 59 , to Sept. 26, 19 59 , that I last saw the deceased alive on Sept. 26, 19 59 , and that death occurred at 11 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE M. J. Elin M.D. 8627 Liberty Rd.				ADDRESS (Street, city or town, state) Randallstown, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) M. J. Elin, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey Howard Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PAUL CHENOWETH 3617 Chestnut Av. Balto. 11				24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE William B. Kane	

CERTIFICATE OF DEATH

FILE NO. 10

DATE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

PLACE OF DEATH

DECEASED'S ADDRESS

DECEASED'S OCCUPATION

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S MARRIAGE

DECEASED'S RELIGION

DECEASED'S EDUCATION

DECEASED'S SERVICE

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S MARITAL STATUS

DECEASED'S SEX

DECEASED'S RACE

DECEASED'S AGE

DECEASED'S DATE OF BIRTH

DECEASED'S PLACE OF BIRTH

DECEASED'S MARRIAGE

DECEASED'S RELIGION

DECEASED'S EDUCATION

DECEASED'S SERVICE

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S MARITAL STATUS

DECEASED'S SEX

DECEASED'S RACE

DECEASED'S AGE

DECEASED'S DATE OF BIRTH

DECEASED'S PLACE OF BIRTH

DECEASED'S MARRIAGE

DECEASED'S RELIGION

DECEASED'S EDUCATION

DECEASED'S SERVICE

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S MARITAL STATUS

DECEASED'S SEX

DECEASED'S RACE

DECEASED'S AGE

DECEASED'S DATE OF BIRTH

DECEASED'S PLACE OF BIRTH

1 09940 09905 014 M 014 1 2 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6yr3dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15				3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2830 Park Avenue 3501 Lucille Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GERMAINE D. CIRIGLIANO (Also Melvin)				4. DATE OF DEATH Month September Day 25 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1901	
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months 57		IF UNDER 24 HRS. Days 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) France				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Demerest				14. MOTHER'S MAIDEN NAME Bertha Dutox Germaine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarctions DUE TO (c) Coronary sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 19 58 , to Sept. 25, 19 59 , that I last saw the deceased alive on Sept. 25, 19 59 , and that death occurred at 12:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-25-59							
ACTUAL SIGNATURE Stella Wachsler				M.D. SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons				24a. REC'D BY REGISTRAR DATE SEP 28 59		24b. REGISTRAR'S SIGNATURE William J. Tiekner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>645 Orpington Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE - CECILIA - CITRANO</u>		4. DATE OF DEATH <u>Sept. 30 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1880</u>
9. AGE (In years last birthday) <u>79</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred Boulay</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>41-34-5561</u>	
17. INFORMANT <u>Julius P. Blake</u>		Address <u>645 Orpington Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X</u> <u>Chronic Abdominal Aorta, Rupture</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture compression, dorsal vertebrae</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall, August 13, 1959, in home</u>	
20c. TIME OF INJURY Month, Day, Year <u>Aug 13 1959</u> Hour a. m. <u>1:00</u> p. m. <u>Aug 13 1959</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Baltimore 28</u> (County) <u>-</u> (State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>Dec 1957</u> , to <u>30 Sept 1959</u> , that I last saw the deceased alive on <u>29 Sept 1959</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Nolan</u>		M.D. <u>1 Mallory Hill Ave Baltimore 29</u>	
PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN</u>		<u>BALTIMORE 29 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 3 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Geifel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>Oct 2 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodbrook Lane-Towson, Md.				d. STREET ADDRESS 1738 Druid Hill Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle E. Last Clark				4. DATE OF DEATH Month Sept. Day 28 , Year 1959			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1900		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Maiseville, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Newton				14. MOTHER'S MAIDEN NAME Rebecca Clevon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-6845		17. INFORMANT Address Mr. Jake Newton-660 Fairmount Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 10 yrs. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home-1631 Druid Hill Ave				24a. REC'D BY REGISTRAR Oct 6 1959		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kraw</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
10/3/59		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Signature of Registrar	
10/5/59		Baltimore		[Signature]	

RECEIVED
OCT 5 1959
STATE OFFICE BLDGS. - BALTO.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09943

CERTIFICATE OF DEATH

Reg. Dist. No.

09308

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 118 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 2 Pine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Served as BRICE (NMI) COLEMAN) BRICE K. COLEMAN		4. DATE OF DEATH Month September Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1896) September 15, '96
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Can Maker	11. BIRTHPLACE (State or foreign country) Cambridge, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Easton Coleman	
14. MOTHER'S MAIDEN NAME Eliza Sampson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 214-07-7035		17. INFORMANT Address Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. ARTERIO DIVERTICULITIS COLON WITH OBSTRUCTION CARCINOMA, KIDNEY, LEFT METASTATIC CARCINOMA LIVER AND LEFT ADRENAL		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8 , 19 59 , to September 3, 1959 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD. FORT HOWARD DIV. 9/3/59			
ACTUAL SIGNATURE John W. Crawford		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/1959	
22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herbert St. Clair Funeral Home, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09909

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE c. LENGTH OF STAY IN 1b 2 WKS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 WEST ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1613 DIVISION AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRAHAM WINFIELD CRANSTON		4. DATE OF DEATH Month SEPT Day 3 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1879
9. AGE (In years, last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDING		10b. KIND OF BUSINESS OR INDUSTRY HOME CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME WILLIAM A. CRANSTON		14. MOTHER'S MAIDEN NAME AMOS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS E. W. CRANSTON, WEST RD, TOWSON 4, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 591X DUE TO Conditions, if any, which gave rise to immediate cause (b) ACUTE NEPHROSIS (c) ACUTE NEPHROSIS DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH 9 MOS. 2 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury		DATE SIGNED 9/3/59	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-6-59	22c. NAME OF CEMETERY OR CREMATORY ST. JAMES EPISCOPAL	22d. LOCATION (City, town, or county) (State) NIGHTKTON - MD.
23. FUNERAL DIRECTOR'S SIGNATURE W M COOK - TOWSON, INC - TOWSON, MD		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles E. Kinn	

FOR STATE
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
DEPARTMENT OF HEALTH - BALTIMORE 18
DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 100

DEPARTMENT OF HEALTH - BALTIMORE 18
DEPARTMENT OF HEALTH - BALTIMORE 18

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DEPARTMENT OF HEALTH - BALTIMORE 18

DEPARTMENT OF HEALTH - BALTIMORE 18

09945

CERTIFICATE OF DEATH

Reg. Dist. No.

09910

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4705 Charlton Avenue	
3. NAME OF DECEASED (Type or print) Served As: First ELIAS Middle J. Last CUMBEST JAMES E. CUMBEST, SR.		4. DATE OF DEATH Month September Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/96
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	11. IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Sales City, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elias J. Cumbest		14. MOTHER'S MAIDEN NAME Marzillie Shiver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-01-3437	
17. INFORMANT WW I		Address Clin. Rec. VAH, Balto 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL ABDOMINAL CARCINOMATOSIS 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA OF RECTOSIGMOID DUE TO (c) 3		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS APPROX. 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VE		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1959 to September 6, 1959 and that death occurred at 11:15 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter C. Goldstein		ADDRESS (Street, city or town, state) VAH, BALTO 18, MD., FORT HOWARD DIVISION	
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.		DATE VAH, BALTO, 18, MD. FORT HOWARD DIV. 9/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Inc.		24a. REC'D BY REGISTRAR SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL OFFICE

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TO THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
FROM THE SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08911

09946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE, <i>md</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rodgers Forge</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mercy Villa Bellona Ave</i>		d. STREET ADDRESS <i>Hopkins Apts 310 1/2 Paul St</i>	
3. NAME OF DECEASED (Type or print) <i>ELIZABETH F DALY</i>		4. DATE OF DEATH <i>Sept 17 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 16 1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>85</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Balto md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Daly</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Ragan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Susan Kahl</i>		Address <i>3885 33rd St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis, senile</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i> <i>10 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 30, 1946</i> to <i>Sept 17, 1959</i> , that I last saw the deceased alive on <i>Sept 8, 1959</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frederick J. Vollmer</i>		ADDRESS (Street, city or town, state) <i>600 York Rd Balto md</i>	
DATE SIGNED <i>9/18/59</i>			
PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>Sept 19/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W Jenkins</i>		ADDRESS <i>Ans Co 4905 York Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u> <u>20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>210 Langley Rd</u> <u>20</u>		d. STREET ADDRESS <u>210 Langley Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Daniel Davis</u>		4. DATE OF DEATH <u>Sept 16</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1907</u>
9. AGE (in years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RR Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hoyd Davis</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Arnold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-10-7558</u>	
17. INFORMANT <u>Ida Davis</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 hours</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		DATE SIGNED <u>9-17-59</u>	
EXAMINER'S NAME (Type) <u>JACK C Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brothers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Flintstone Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brydzinski</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '59</u>	
ADDRESS <u>1407 Eastern Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained by the funeral director. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John J. Smith*
AGE: *45* SEX: *M*
RESIDENCE: *123 Main St, Boston, Mass.*
DATE OF DEATH: *Jan 15, 1910*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Myocardial Infarction*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *[Signature]*
DATE: *Jan 16, 1910*

1. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

2. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

3. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

4. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

5. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

6. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

7. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

8. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

9. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

10. I hereby certify that the above is a true and correct statement of the facts ascertained by me in the examination of the body of the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09913

09948

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr7mth26dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS Arnold, Maryland	
3. NAME OF DECEASED (Type or print) First Charles Middle Derschinger Last Derschinger		4. DATE OF DEATH Month Sept. Day 7 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 85 Days 7 Hours 19 Min. 59	IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired potter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Martin Derschinger		14. MOTHER'S MAIDEN NAME Elizabeth Alt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown none	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and pulmonary abscesses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 8, 1957 to Sept. 7, 1959 , that I last saw the deceased alive on Sept. 7, 1959 , and that death occurred at 9:30 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE SIGNED 9-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/59	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Licknerthaus		ADDRESS At Pa Ave	
24a. REC'D BY REGISTRAR SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09949

CERTIFICATE OF DEATH

Reg. Dist. No.

09914

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4321 Kenwood Ave.</u>		d. STREET ADDRESS <u>4321 Kenwood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Dietel</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Neubauer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Bodenschatz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>John T. Dietel</u> Address <u>4321 Kenwood Ave.</u>		<u>6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1953, to <u>Sept 16</u> , 1959, that I last saw the deceased alive on <u>Sept 16</u> , 1959, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max R. English</u> M.D.		ADDRESS (Street, city or town, state) <u>5713 Belair Rd</u> DATE SIGNED <u>9-17-59</u>	
PHYSICIAN'S NAME (Type) <u>Max R. ENGLISH</u> M.D.		<u>Baltimore 6 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gosselin Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1944

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09915

09959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Indian Head Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MATTISON HENRY DOUGHTY		4. DATE OF DEATH Month Day Year Sept. 15, 1959 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Doughty		14. MOTHER'S MAIDEN NAME Elizabeth Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 712-14-3956	
17. INFORMANT Mrs. Robt. W. Jenkins		Address 1906 Indian Head Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scirrhus carcinoma of left ear with 199.1 DUE TO generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21, 1959 to Sept. 15, 1959 , that I last saw the deceased alive on Sept. 14, 1959 , and that death occurred at 9:45 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lloyd E. Saylor		M.D. 3902 Greenmount Avenue DATE SIGNED 9/15/59	
PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		Baltimore 18, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/18/59	
22c. NAME OF CEMETERY OR CREMATORY Fairmount		22d. LOCATION (City, town, or county) (State) East Orange, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		ADDRESS 1050 York Rd. Towson	
24a. REC'D BY REGISTRAR SEP 17 '59		24b. REGISTRAR'S SIGNATURE Carlton E. Hines	

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sikesville</u> 06X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>44 Central Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Earle</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-83</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sheppards town W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moses A Kimes</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>002X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11-1959</u> to <u>9-9-1959</u> , that I last saw the deceased alive on <u>9-9-1959</u> , and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED <u>9-9-59</u>			
ACTUAL SIGNATURE <u>William Newcomer</u>		PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u> Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Clydeville, Panola, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Wright</u>		ADDRESS <u>Clydeville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09917

09952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7401 Kenlea Ave.				d. STREET ADDRESS 7401 Kenlea Ave.																			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Robert Eberline				4. DATE OF DEATH Month Day Year Sept. 5 19 59																			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																			
8. DATE OF BIRTH May 16, 1893		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Market		11. BIRTHPLACE (State or foreign country) Balto. Md.																			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME August Eberline																			
14. MOTHER'S MAIDEN NAME Elizabeth Horner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No																			
16. SOCIAL SECURITY NO. 218-32-0786		17. INFORMANT Address Mrs. Elizabeth Eberline 7401 Kenlea Ave.																					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="3"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemoptysis </td> </tr> <tr> <td colspan="3"> DUE TO </td> </tr> <tr> <td colspan="3"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> </tr> <tr> <td colspan="3"> (b) Carcinoma of lung, right </td> </tr> <tr> <td colspan="3"> DUE TO </td> </tr> <tr> <td colspan="3"> (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemoptysis			DUE TO			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Carcinoma of lung, right			DUE TO			(c)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemoptysis																							
DUE TO																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b) Carcinoma of lung, right																							
DUE TO																							
(c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)																			
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.																							
ACTUAL SIGNATURE <i>W. Bradley King, Jr.</i>		EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith																			
22d. LOCATION (City, town, or county) Baltimore, Md.		22e. (State)																					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loraine Funeral Home</i>		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE SEP 8 '59																			
24b. REGISTRAR'S SIGNATURE <i>Orlino & Kram</i>																							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 2 X
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G249 9-28-59 et
09953
CERTIFICATE OF DEATH

09918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY in 1b <u>3 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1709 Reisterstown Road (Private home)</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>#7 Georgia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marie</u> First <u>M.</u> Middle <u>Eckman</u> Last 4. DATE OF DEATH <u>Sept.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>16 January 1898</u> 9. AGE (In years last birthday) <u>61</u> yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Unknown (Schaefer)</u> 14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>WWII</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Charles M. Eckman - Same As #2</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>442X</u> DUE TO <u>Uremic Coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>Left Hemiplegia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Hemiplegia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 14</u> 19 <u>59</u> , to <u>Sept 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 18</u> , 19 <u>59</u> , and that death occurred at <u>3 a.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis R. Maser</u>				ADDRESS (Street, city or town, state) <u>4335 Park Heights Ave</u> DATE SIGNED <u>9/19/59</u>			
PHYSICIAN'S NAME (Type) <u>L.R. MASER M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>21 Sept-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino & Thoma</u>	

CERTIFICATE OF DEATH

000000

See Code, 10

PLACE TO BE FILLED

DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Age of deceased

5. Sex of deceased

6. Race of deceased

7. Marital status of deceased

8. Occupation of deceased

9. Cause of death

10. Date of death

11. Place of death

12. Age of deceased

13. Sex of deceased

14. Race of deceased

15. Marital status of deceased

16. Occupation of deceased

17. Cause of death

18. Date of death

19. Place of death

20. Age of deceased

21. Sex of deceased

22. Race of deceased

23. Marital status of deceased

24. Occupation of deceased

25. Cause of death

26. Date of death

27. Place of death

28. Age of deceased

29. Sex of deceased

30. Race of deceased

31. Marital status of deceased

32. Occupation of deceased

33. Cause of death

34. Date of death

35. Place of death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3030 Dunglew Road		d. STREET ADDRESS 3030 Dunglew Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ADOLPHUS H.D. EDWARDS, Sr.		4. DATE OF DEATH Month Day Year September 22, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cold Roll Supt.		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Edwards		14. MOTHER'S MAIDEN NAME Jeanette ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-10-6494	
17. INFORMANT Mrs. Wm. Vitek		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1949 to Sept 22, 1959 that I last saw the deceased alive on Sept 22, 1959 and that death occurred at 11 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE David H. Andrew M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 33 Dundalk Ave Dundalk 22 Md. 9/24/59	
PHYSICIAN'S NAME (Type) David H. Andrew			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/59	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley & Son		ADDRESS Dundalk 22	
24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	

CERTIFICATE OF DEATH

Reg. Dist. No.

09954

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 29 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle A Last EULER				4. DATE OF DEATH Month September Day 30 Year 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 18, 1878	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00		11. IF UNDER 24 HRS. Hours 00 Min. 00		12. IF UNDER 24 HRS. Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Millinery		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ned Euler (Edwin J. Euler)				14. MOTHER'S MAIDEN NAME Augusta Kabernagel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 217-01-4849			
17. INFORMANT Clin. Rec. Vet. Adm. Hospital Ft. Howard, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of ascending colon, removed April, 1958							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 1, 19 59 to September 30, 19 59 , and that death occurred at 1:13 P.M. from the causes and on the date stated above. John W. Crawford M.D. VAH Ft. Howard, Md 9/30/59 ACTUAL SIGNATURE ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, MD. VAH Ft Howard, Md 9/30/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-3-59			
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave. Balto. Md			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons Inc. North & Pennsylvania Balto. Md				24a. REC'D BY REGISTRAR 1 '59			
24b. REGISTRAR'S SIGNATURE Arthur A. Thomas							

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

三、研究结论与讨论

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 15 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MERRELL Middle H. Last EVANS		4. DATE OF DEATH Month September Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1896
9. AGE (In years last birthday) yrs. 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	
11. BIRTHPLACE (State or foreign country) Hollands Island, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George T. Evans		14. MOTHER'S MAIDEN NAME Lottie C. Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec. VAH. Balto 18, Md., Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 17, 1959 to September 1, 1959 and that death occurred at 8:20 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO MD. Y FORT HOWARD DIV. 9/1/59			
ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTO MD. Y FORT HOWARD DIV. 9/1/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/59	
22c. NAME OF CEMETERY OR CREMATORY Tilghman Cemetery		22d. LOCATION (City, town, or county) (State) Tilghman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Leeds Moore		ADDRESS Tilghman, Md.	
24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09922

09904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give street) Highlands c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4012 Annapolis Road.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Highlands d. STREET ADDRESS 4012 Annapolis Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle J. Last Faulkner				4. DATE OF DEATH Month September Day 2 Year 1950			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 26 1880	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Book Retired		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nathan Faulkner		14. MOTHER'S MAIDEN NAME Leontine		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) r DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9. 5. 59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Cully - 130 E. Fort Ave.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE SEP 4 1950				DATE SIGNED Sept. 2, 1950			

09956

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7807 Westmoreland Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Karl Joseph Finger</i>		4. DATE OF DEATH <i>Sept. 10, 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Continental Can Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Finger</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Kolloch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>212-03-3408</i>	
17. INFORMANT <i>Mrs. Augusta G. Finger,</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the head of the pancreas</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>9/12 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-25</i> , 19 <i>59</i> to <i>9-10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9-9</i> , 19 <i>59</i> , and that death occurred at <i>3:55 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Skloven, M.D.</i>		ADDRESS (Street, city or town, state) <i>7122 Harford Rd, Baltimore 15 Md</i>	
PHYSICIAN'S NAME (Type) <i>Joseph Skloven, M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/15/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>SEP 14 '59</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

ORIGINAL

CERTIFICATE OF DEATH

Name of deceased		Age		Sex		Race		Color		Religion		Marital status		Occupation		Cause of death		Date of death		Place of death		Signature of physician		Signature of registrar		Signature of informant	
John Doe		45		Male		White		Caucasian		Protestant		Married		Farmer		Heart disease		Jan 1, 1912		Farm		Dr. J. Smith		J. Doe		J. Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03924

09957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55</u> <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1812 Deveron Road</u>				d. STREET ADDRESS <u>1</u> <u>1812 Deveron Road</u> <u>#4</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE</u> <u>A.</u> <u>XXXXX</u> <u>FINK</u>				4. DATE OF DEATH Month Day Year <u>September</u> <u>11</u> <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Dec. 26, 1880</u>			
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? 				 			
13. FATHER'S NAME <u>Adam ?</u>				14. MOTHER'S MAIDEN NAME <u>Caroline ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-4328</u>		17. INFORMANT Address <u>Mrs. Margaret E. Settle-1812 Deveron Road</u> <u>#4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Partial</u>			
20f. (City or town) (County) (State)		 					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles S. Petty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/12/59</u>			
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>		 					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		 					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>			
ADDRESS <u>Balto - 17, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Carlton B. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09925

09958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mth13dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Fischhaber Last Fishhaber		4. DATE OF DEATH Month September Day 4 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 Mar. 15
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months 7 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baker		10b. KIND OF BUSINESS OR INDUSTRY BAKING	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Fishhaber		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown NONE		16. SOCIAL SECURITY NO. 216-03-2435	
17. INFORMANT Recorded: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorenal failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 20, 1958 , to Sept. 4, 1959 , that I last saw the deceased alive on Sept. 4, 1959 , and that death occurred at 8:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-4-59 ACTUAL SIGNATURE Stella Wachslar PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-7-59	
22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEMORIAL		22d. LOCATION (City, town, or county) (State) ELK Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Schwa		24a. REC'D BY REGISTRAR SEP 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans		24c. REGISTRAR'S SIGNATURE Arthur L. Evans	

CERTIFICATE OF DEATH

Reg. Dist. No.

09926

09959

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 46 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 2339 Druid Hill Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle Last Fletcher		4. DATE OF DEATH Month 9 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/96
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Boxton, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Barnett Fletcher		14. MOTHER'S MAIDEN NAME Esther Lesser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diarrhea with severe dehydration 785.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonian Syndrome since 1945			INTERVAL BETWEEN ONSET AND DEATH 30 hours.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1943 , 19____, to 9/4 , 19 59 that I last saw the deceased alive on 9/4 , 19 59 , and that death occurred at 4:10a , from the causes and on the date stated above.			
ACTUAL SIGNATURE Viola B. Johns		ADDRESS (Street, city or town, state) Rosewood State Training School DATE SIGNED 9/4/59	
PHYSICIAN'S NAME (Type) Viola B. Johns, M.D.		Owings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 6/59	22c. NAME OF CEMETERY OR CREMATORY BETH YEHILDA ANSHE KURLAND	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Sal Levinson + Bros		24a. REC'D BY REGISTRAR SEP 9 '59	
ADDRESS 1124 W. North		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02552

Decedent's name (printing name) William H. Jones
Residence 1234 Main Street, Baltimore, Maryland

Age 45 years 10 months 15 days

Place of death Home, 1234 Main Street, Baltimore, Maryland

Time of death 10:30 AM 10 day of May 1945

Cause of death Myocardial Infarction

Signature of physician Dr. J. H. Smith

Signature of coroner John D. Doe

Signature of registrar John D. Doe

Signature of informant John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

Signature of witness John D. Doe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of Bines 16 Trusting ave</u>		d. STREET ADDRESS <u>200 E Randall St</u>	
3. NAME OF DECEASED (Type or print) <u>William H. Fritz</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prose</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Adam Fritz</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Siegle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Henry Fritz 15 Paultrney W</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Generalized arterio sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>82</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2</u> , 19 <u>55</u> , to <u>9/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>59</u> , and that death occurred at <u>19</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Deibel</u>		DATE SIGNED <u>1226 Roman St Balto 30</u>	
PHYSICIAN'S NAME (Type) <u>DR. HARRY DEIBEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 14, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Graham Evans</u>		ADDRESS <u>1400 Scharb</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

09928

CERTIFICATE OF DEATH

Reg. Dist. No.

09961

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore 18			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson - 4				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1413 Putty Hill Rd.				d. STREET ADDRESS 4 East 32nd St.			
3. NAME OF DECEASED (Type or print) First MIRIAM Middle BOWLES Last GILE				4. DATE OF DEATH Month Sept. Day 4 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.	IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interviewer, Md. Dept. of Employment Security - Maryland				10b. KIND OF BUSINESS OR INDUSTRY USA			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ? Bowles				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA Clinically DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinoma Metastases DUE TO (c) Carcinoma of Rectum				INTERVAL BETWEEN ONSET AND DEATH Days weeks months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/3/59 to 9/4/59 , that I last saw the deceased alive on 9/3/59 , and that death occurred at 9:45 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. K... M.D.				ADDRESS (Street, city or town, state) 1526 Stonewood Rd. Baltimore Md.			
PHYSICIAN'S NAME (Type) William F. K...				DATE SIGNED 9/4/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF Sept. 7, 1959			
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery.				22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.				24a. REC'D BY REGISTRAR SEP 8 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. K...							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1933

CERTIFICATE OF DEATH

1933



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09962 Items 8,9 Film 6248 9-21-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7330 GERMAN HILL RD.</u>			d. STREET ADDRESS <u>17330 GERMAN HILL RD.</u>		
3. NAME OF DECEASED (Type or print) <u>BOLESZAW (Ben) GRABOWSKI</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>8</u> Year <u>19 59</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/89</u>		9. AGE (In years last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE MIXER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUBEROID CO.</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
13. FATHER'S NAME <u>IGNATIUS GRABOWSKI</u>			14. MOTHER'S MAIDEN NAME <u>MARY NOWAK</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-01-5394</u>		17. INFORMANT <u>BERNARD GRABOWSKI</u> Address <u>3507 Gough St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO <u>A S-C-U DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AS-C-U DISEASE</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/10/59</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART MARY</u>	
22d. LOCATION (City, town, or county) <u>BALTIMORE</u>		22e. (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>RAYMOND L. KACZOROWSKI</u>		ADDRESS <u>3535 KENYON ST.</u>		40. REC'D BY REGISTRAR <u>SEP 16 '59</u>	
24a. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

09963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN lb 42 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berryman's Lane				e. STREET ADDRESS Berryman's Lane			
3. NAME OF DECEASED (Type or print) First Lena Middle Wilhelmina Last Green				4. DATE OF DEATH Month September Day 19 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1 1914	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Vaughn				14. MOTHER'S MAIDEN NAME Katherine Gauss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-18-0313		17. INFORMANT John W Green Owings Mills Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410X due DUE TO Inflammatory rheumatism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 20 years or more	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 1-1-1930 to 9-19-59 , 19____, that I last saw the deceased alive on 9-18-59 , 19____, and that death occurred at 4:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Saffell				ADDRESS (Street, city or town, state) Reisterstown Md			
PHYSICIAN'S NAME (Type) James G. Saffell M.D.				DATE SIGNED 9-24-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 22 1959		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman + Sons				24a. REC'D BY REGISTRAR DATE SEP 22 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09964

CERTIFICATE OF DEATH

Reg. Dist. No.

09933

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 12 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2000 Eastern Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDWARD Middle A. Last GRYNKIEWICZ				4. DATE OF DEATH Month September Day 9 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1899	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor				10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Vincent Gryniewicz				14. MOTHER'S MAIDEN NAME Sophia Bernadzikowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes				16. SOCIAL SECURITY NO. 217-32-756			
17. Informant Address Division Clin. Records, VA Hospital, Balto. 18, Md. Ft. Howard							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 INDEX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA INDEX (c) PULMONARY ABSCESS INDEX (c) PULMONARY HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECENT RECENT RECENT							
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that the deceased John W. Crawford died on August 28 , 19 59 , at 5:45 A.M. , from the causes and on the date stated above. VAH, BALTO. 18, MD. FT. HOWARD DIV. 9/9/59							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV.							
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD., FT. HOWARD DIV.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/12/59 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. S. Fialowski 2007 Eastern Ave. Balto 31, Md. 24a. REC'D BY REGISTRAR DATE SEP 10 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1935

(11)

2000 Madison Avenue

12 Ave

Fort Howard

Veterans Administration Hospital

September

WINSTON

STANT

April 1, 1933

White

late

Belmont, Maryland

Howard

Inspector

Vincent G. Gendron

Joseph Gendron

Clin. Records VA Hospital, Baltimore, Md.

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August 28

VA

VAH BILTO 18, ST. HOWARD INV.

VAH BILTO 18, ST. HOWARD INV.

WYATT, J. W.

Belmont, Maryland

WYATT, J. W.

WYATT

WYATT, J. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09934

09965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Middle River 30</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>38 De hedral Dr</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Minnie Louise Hahn</i>		4. DATE OF DEATH Month Day Year <i>Sept 11 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-19-1873</i>
9. AGE (In years last birthday) yrs. <i>86</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Carl DeMeque</i>		14. MOTHER'S MAIDEN NAME <i>Hannah S Kruger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Laurenda M. Sander</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive heart failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio-sclerotic cardiovascular disease</i> DUE TO (c) <i>10911</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar</i> 19 <i>55</i> , to <i>Sept 11</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Sept 11</i> , 19 <i>59</i> , and that death occurred at <i>930 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis Semenov</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>2108 O REMS RD 9/11/59</i>	
PHYSICIAN'S NAME (Type) <i>LOUIS SEMENOFF</i>		<i>Baltimore 20, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>9-3-1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hansen Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Hansen Wisconsin</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Guggenbuehler</i>		ADDRESS <i>1407 Eastern Ave 21 Md</i>	
24a. REC'D BY REGISTRAR <i>SEP 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Cooking & House</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

09905

09935

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1271 Birch Ave.</u>				d. STREET ADDRESS <u>1271 Birch Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN T. HAMMOND</u>				4. DATE OF DEATH Month Day Year <u>Sept. 8, 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1896</u>		9. AGE (In years last birthday) <u>63 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>John Worthington Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Mary Anna Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Ruth H. Hammond - 1271 Birch Ave. #27</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Sept 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>59</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>I. EARL PASS</u>				ADDRESS (Street, city or town, state) <u>4001 W. Ikens Ave. #9-8-59</u>			
PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>				DATE SIGNED <u>Balto 29 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Schuler & Sons - Balto.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Schuler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1X M X VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death. 09966 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09966 CERTIFICATE OF DEATH Reg. Dist. No.

09936

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3608 Latham Rd.</u>		d. STREET ADDRESS <u>3608 Latham Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>T.</u> Last <u>HART</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> , Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Von Klenke</u>		14. MOTHER'S MAIDEN NAME <u>Nannie MacDonaldsen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>		17. INFORMANT Address <u>Mr. LeRoy Wood - 3608 Latham Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2 METASTATIC CARCINOMA LUNGS-PRIMARY</u> DUE TO <u>SITE UNDETERMINED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 MO</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-24</u> , 19 <u>59</u> , to <u>9-31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>59</u> , and that death occurred at <u>6:00 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Stanley Cohen</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7306 Liberty Rd Balto 7, Md 9-22-59</u>	
PHYSICIAN'S NAME (Type) <u>B. STANLEY COHEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blum J. Liekner & Sons - Balto 17</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1955

DATE OF DEATH

PLACE

DECEASED'S NAME (Last, first, middle initial)

DECEASED'S ADDRESS (Street, city, state, zip)

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09937

09967

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto(rural-)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 6108 Shadyspring	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Margret Ann Hawkins		4. DATE OF DEATH Month Sept Day 4 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6Mar 55
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas Hawkins		14. MOTHER'S MAIDEN NAME Alice Baublitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Alice Hawkins(mother) same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull with Extrusion of Brain 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH inst
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Skull crushed by rear wheel of truck	
20c. TIME OF INJURY Month, Day, Year 4:50 p. m. 9-4-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Balto(rural) Balto MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C. Hyle MD		DATE SIGNED 9-4-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-5-59	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cvach		24a. REC'D BY REGISTRAR DATE SEP 10 '59	24b. REGISTRAR'S SIGNATURE Arthur A. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.

RECEIVED IN THE OFFICE OF THE
STATE MEDICAL DEPARTMENT
JAN 10 1933

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Belts

(Initials) (Initials)

6108 and 6109

Sept 4

Gar 22

Alice

Hampton

Thomas

Alice (sister) same

Crushed skull with fracture of brain

Lead

Skull crushed by iron wheel of truck

7-1-33

(Initials) (Initials) Belts M.M.

Belts M.M.

2-1-33

John C. Hyle, MD

Handwritten notes and signatures at the bottom of the page, including "John C. Hyle, MD" and "Belts M.M."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09968
CERTIFICATE OF DEATH

09940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 19 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOCKWOOD HENSON		4. DATE OF DEATH Month September Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/95
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Ward Baking Co.	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Henson		14. MOTHER'S MAIDEN NAME Harriet Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-09-1686	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 465X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 - 6 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DESTRUCTIVE LESION T5 - T6		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 17, 1959 , to Sept. 5, 1959 , and that death occurred at 3:15 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ARTHUR T. FAULK, M.D. VAH, BALTO 18, MD. FORT HOWARD DIV. 9/5/59			
ACTUAL SIGNATURE Arthur T. Faulk, M.D.		PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D. VAH, BALTO 18, MD. FORT HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09939

09969

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 2 8		c. LENGTH OF STAY IN 1b 2 Mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair 1232.2		d. STREET ADDRESS 25 E. Courtland Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVELYN Middle VIRGINIA Last HILL		4. DATE OF DEATH Month September Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 24, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	11. IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Forsythe		14. MOTHER'S MAIDEN NAME Virginia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Earl M. France		Address 932 Bardswell Rd. Balto. 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ART BRINSELENTIC CARDI - URSEMAN 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DISEASE - PULMONARY EDEMA - DUE TO (c) CHRONIC DIPHTHERIA - CA COLIN ?		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1 , 1959, to 9/23 , 1959, that I last saw the deceased alive on 9/23 , 1959, and that death occurred at 7 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/25/59 ACTUAL SIGNATURE John H. Shaw M.D. John H. Shaw M.D. PHYSICIAN'S NAME (Type) John H. Shaw M.D. BALTO 28, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 26, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Fountain Green, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville, 28, Md.		24a. REC'D BY REGISTRAR SEP 28 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

RECEIVED
FEB 24 1953
U.S. DEPT. OF JUSTICE

00888

OFFICE OF THE ATTORNEY GENERAL

00888

MEMORANDUM FOR THE ATTORNEY GENERAL
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The remainder of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09970

CERTIFICATE OF DEATH

Reg. Dist. No.

09941

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Baltimore b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Randallstown Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 8615 Liberty Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA FLORENCE HOBBS		4. DATE OF DEATH Month September Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin J. Hobbs		14. MOTHER'S MAIDEN NAME Catherine Warthon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Albert Migan 8615 Liberty Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior-sclerosis (c) Obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity INTERVAL BETWEEN ONSET AND DEATH 5 mts			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 59 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to Sept 10, 1959 , that I last saw the deceased alive on Sept 10, 1959 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center, Pikesville 8148 DATE SIGNED 9/14/59			
ACTUAL SIGNATURE Louis Dalman PHYSICIAN'S NAME (Type) GEORGE RAMAPURAN		M.D. Medical Center, Pikesville 8148 Pikesville Medical Center Pikesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 9-16-59	
22c. NAME OF CEMETERY OR CREMATORY Montevista Cemetery		22d. LOCATION (City, town, or county) (State) Johnson City, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE ELLSWORTH ARMACOST		24a. REC'D BY REGISTRAR SEP 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinard			

09971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 120 Days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS TILGHMAN 20 X-2			
3. NAME OF DECEASED (Type or print) First FRANK Middle - - Last HOLLER				4. DATE OF DEATH Month SEPTEMBER Day 11 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 3, 1892	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED HOLLER				14. MOTHER'S MAIDEN NAME ELLEN SWARTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 206-03-4894		INFORMANT Address CLIN REC VAH BALTIMORE MD- FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARCINOMA OF LUNG, RIGHT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADHESIVE PERICARDITIS; CHRONIC PASSIVE CONGESTION OF LIVER						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from 5-14-59 , 19 Sept. 11 , 19 59 at 11:35p M, from the causes and on the date stated above. and that death occurred on 11:35p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John D. Talbert M.D. VAH				ADDRESS (Street, city or town, state) Fort Howard Maryland DATE SIGNED 9-13-59			
PHYSICIAN'S NAME (Type) JOHN D. TALBERT				VAH Fort Howard Maryland 9-13-59			
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 9-14-59		22c. NAME OF CEMETERY OR CREMATORY MAYSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MAYSVILLE, PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc., 6009 Harford Rd., Balto., Md.				24a. REC'D BY REGISTRAR SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Hines	

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SHIP TO: BAIRD FUNERAL HOME, GREENVILLE, PENNA.

ON 11-13-79, NEW YORK POLICE DEPARTMENT (NYPD) ADVISED THAT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09943

09972

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkton-Rural</i>		c. LENGTH OF STAY IN 1b <i>Rural-Parkton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hereford</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>H.</i> Last <i>Hoover</i> Jr.		4. DATE OF DEATH Month <i>September</i> Day <i>25</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 11, 1891</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>6</i> Days <i>14</i> Hours <i>18</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Service St. Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Service Station Balto. Co., Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Adam Hoover</i>		14. MOTHER'S MAIDEN NAME <i>Francis Esterline</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>218-22-0489</i>	
17. ADDRESS <i>Adm. Hoover, Parkton Md. R.D.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>few hrs</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 26, 1959</i> to <i>Sept 25, 1959</i> that I last saw the deceased alive on <i>Sept 25, 1959</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Milner Bortner</i> M.D.		ADDRESS (Street, city or town, state) <i>White Hall, Md.</i> DATE SIGNED <i>9/26/59</i>	
PHYSICIAN'S NAME (Type) <i>Milner Bortner</i>		<i>White Hall Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 28, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hereford Baptist Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Parkton, Md. R.D.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Hartenstein</i> ADDRESS <i>New Freedom, Pa</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 30 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur P. Hines</i>	

MEDICAL CERTIFICATION

09973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 W. Timonium Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
3. NAME OF DECEASED (Type or print) First LOUISE Middle L. Last HOUGHTON		4. DATE OF DEATH Month Sept. Day 2 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1870
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rtd)		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John L. Ringwalt		14. MOTHER'S MAIDEN NAME Jessie Elder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT H. R. Houghton - 229 W. Timonium Rd.		Address Timonium, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 30, 1959 to Sept. 2, 1959 , that I last saw the deceased alive on August 30th , 19 59 , and that death occurred at 2:20 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED M. X. Quinn M.D. 1927 York Rd, Timonium 9/4/59			
ACTUAL SIGNATURE M. X. Quinn			
PHYSICIAN'S NAME (Type) M. X. Quinn			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto.		ADDRESS 17 Md.	
24a. REC'D BY REGISTRAR DA SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934

CERTIFICATE OF DEATH

1934

RECEIVED
JAN 11 1934

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09945

09897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3001 Dunglew Road		d. STREET ADDRESS 131 South East Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA ESTELLE JAMISON		4. DATE OF DEATH Month Day Year September 23, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31st, 1882
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Julius Wood		14. MOTHER'S MAIDEN NAME Ida Ortlip	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. W.F. Hoover, Jr.,		Address Same as #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 59 , to 9-22- , 19 59 , that I last saw the deceased alive on 9-22- , 19 59 , and that death occurred at 12:20A from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2900 Dunran Road DATE SIGNED 9/24/59 ACTUAL SIGNATURE B.W. Sollod M.D. Baltimore 22, Maryland PHYSICIAN'S NAME (Type) B.W. Sollod, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
ADDRESS Dundalk 22		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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14. *Journal of the American Medical Association*, 277:1225-1226 (1997).

09974

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRACELAND PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRACELAND PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6713 GRACELAND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE L. JENKINS		4. DATE OF DEATH SEPTEMBER 12, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 21, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE LAWTON		14. MOTHER'S MAIDEN NAME RHODA CHARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. YES	
17. INFORMANT MRS EURITH HARMON		Address (SAME)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular disease 422.1 DUE TO Arteriosclerotic Cardio Vasculardisease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 2 yrs (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 wk			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1959 , to Sept 12, 1959 , that I last saw the deceased alive on Sept 12, 1959 , and that death occurred at 2:35 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 9/12/59 ACTUAL SIGNATURE W Baumgardner PHYSICIAN'S NAME (Type) HE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/15/59	
22c. NAME OF CEMETERY OR CREMATORY MAGOTHY CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) ANNA ARUNDAL COUNTY	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC		ADDRESS BALTIMORE 13, MARYLAND	
24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Colburn & Kiana	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10010

STATE OF NEW YORK

10010

10010

10010

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton				c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) L' Hirondelle Club				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edgar Middle D. Last Johnson				4. DATE OF DEATH Month Sept. Day 12 Year 19 59			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 60 Days 00 Hours 00 Min.	IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CATERER & Helper Airplane Factory				10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Armond Johnson				14. MOTHER'S MAIDEN NAME LEANNA COLEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI-USN 216-05-4696			
17. INFORMANT ANN D. JOHNSON				Address 3316 Leighton Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 Hr							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F O'Donnell				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/16/59		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lynch				ADDRESS 3463 Druid Hill		24a. REC'D BY REGISTRAR SEP 15 59	
				24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

DATE SIGNED

9/13/59

QUEST MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. TIME OF DEATH		15. SIGNATURE OF EXAMINER	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY		19. SIGNATURE OF JUDGE		20. SIGNATURE OF CLERK	
21. SIGNATURE OF MEDICAL EXAMINER		22. SIGNATURE OF NURSE		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DENTIST		25. SIGNATURE OF OTHER	
26. SIGNATURE OF CHURCH		27. SIGNATURE OF SCHOOL		28. SIGNATURE OF EMPLOYER		29. SIGNATURE OF FRIEND		30. SIGNATURE OF NEARER	
31. SIGNATURE OF RELATIVE		32. SIGNATURE OF FRIEND		33. SIGNATURE OF NEARER		34. SIGNATURE OF RELATIVE		35. SIGNATURE OF FRIEND	
36. SIGNATURE OF NEARER		37. SIGNATURE OF RELATIVE		38. SIGNATURE OF FRIEND		39. SIGNATURE OF NEARER		40. SIGNATURE OF RELATIVE	
41. SIGNATURE OF FRIEND		42. SIGNATURE OF NEARER		43. SIGNATURE OF RELATIVE		44. SIGNATURE OF FRIEND		45. SIGNATURE OF NEARER	
46. SIGNATURE OF RELATIVE		47. SIGNATURE OF FRIEND		48. SIGNATURE OF NEARER		49. SIGNATURE OF RELATIVE		50. SIGNATURE OF FRIEND	
51. SIGNATURE OF NEARER		52. SIGNATURE OF RELATIVE		53. SIGNATURE OF FRIEND		54. SIGNATURE OF NEARER		55. SIGNATURE OF RELATIVE	
56. SIGNATURE OF FRIEND		57. SIGNATURE OF NEARER		58. SIGNATURE OF RELATIVE		59. SIGNATURE OF FRIEND		60. SIGNATURE OF NEARER	
61. SIGNATURE OF RELATIVE		62. SIGNATURE OF FRIEND		63. SIGNATURE OF NEARER		64. SIGNATURE OF RELATIVE		65. SIGNATURE OF FRIEND	
66. SIGNATURE OF NEARER		67. SIGNATURE OF RELATIVE		68. SIGNATURE OF FRIEND		69. SIGNATURE OF NEARER		70. SIGNATURE OF RELATIVE	
71. SIGNATURE OF FRIEND		72. SIGNATURE OF NEARER		73. SIGNATURE OF RELATIVE		74. SIGNATURE OF FRIEND		75. SIGNATURE OF NEARER	
76. SIGNATURE OF RELATIVE		77. SIGNATURE OF FRIEND		78. SIGNATURE OF NEARER		79. SIGNATURE OF RELATIVE		80. SIGNATURE OF FRIEND	
81. SIGNATURE OF NEARER		82. SIGNATURE OF RELATIVE		83. SIGNATURE OF FRIEND		84. SIGNATURE OF NEARER		85. SIGNATURE OF RELATIVE	
86. SIGNATURE OF FRIEND		87. SIGNATURE OF NEARER		88. SIGNATURE OF RELATIVE		89. SIGNATURE OF FRIEND		90. SIGNATURE OF NEARER	
91. SIGNATURE OF RELATIVE		92. SIGNATURE OF FRIEND		93. SIGNATURE OF NEARER		94. SIGNATURE OF RELATIVE		95. SIGNATURE OF FRIEND	
96. SIGNATURE OF NEARER		97. SIGNATURE OF RELATIVE		98. SIGNATURE OF FRIEND		99. SIGNATURE OF NEARER		100. SIGNATURE OF RELATIVE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09976

CERTIFICATE OF DEATH

Reg. Dist. No.

09948

1. PLACE OF DEATH Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
o. COUNTY Baltimore		MARYLAND		o. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		1615-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 3702 Hamilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cheryl Middle Lynn Last Jones				4. DATE OF DEATH Month 9 Day 18 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/59	
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 5 Days 19		IF UNDER 24 HRS. Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ernest Lee Jones, Sr.				14. MOTHER'S MAIDEN NAME Sarah Ann Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Rosewood Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis - pneumonia 500X DUE TO (b) Acute Bronchitis & aspiration pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus and Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Two days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (State of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 18 Sept 59 to 18 Sept 59 that I last saw the deceased alive on 18 Sept 59 and that death occurred at 1:00 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Harry G. Butler M.D. ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 18 Sept 59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/19/59			
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE SEP 21 '59			
24b. REGISTRAR'S SIGNATURE Archie & Kraus							

26 77233 XV5

TO LEAD . . .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09977

CERTIFICATE OF DEATH

Reg. Dist. No.

15949

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 33 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH First THOMAS Middle E. Last JONES		Month September Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1899
9. AGE (In years last birthday) 60 yrs.		10. UNDER 1 YEAR Months 60 Days	11. UNDER 24 HRS. Hours 60 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lka Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel B. Jones		14. MOTHER'S MAIDEN NAME Ida Gould	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-DI-1144	
17. INFORMANT Clin. Records, VAH, Balto. 18, Md., Fort Howard Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 INTESTINAL OBSTRUCTION DUE TO ADENOCARCINOMA, COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. RECENT METASTATIC ADENOCARCINOMA, LIVER & URINARY BLADDER (b) UNKNOWN (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY CONGESTION AND EDEMA- RECENT			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/21/59			
ACTUAL SIGNATURE _____ M.D.		PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Kelson		24a. REC'D BY REGISTRAR SEP 23 '59	
ADDRESS George Kelson Funeral Home, 1348 N. Calhoun St. Balto 17, Md.		24b. REGISTRAR'S SIGNATURE Ciribus A. Thompson	

CERTIFICATE OF DEATH

1937

Thompson (A)

Fort Howard

1700 W. 10th Street

Veterans Home, Fort Howard

1937

THOMAS

Male

1937

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09978

CERTIFICATE OF DEATH

Reg. Dist. No.

09950

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6408 Sherwood Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> d. STREET ADDRESS <u>6408 Sherwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Lillian M. Kahl</u> First Middle Last				4. DATE OF DEATH <u>Sept. 25, 1959</u> Month Day Year											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John T. Gerlach</u>						14. MOTHER'S MAIDEN NAME <u>Agnes G. Rafferty</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Arthur G. Kahl, 6408 Sherwood Road</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a). <u>Acute Coronary Occlusion</u> <u>4 hours.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis.</u> <u>2 years</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-6-57</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>9-25-59</u> , 19 <u> </u> , and that death occurred at <u>4-15 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1114 St. Paul St.</u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>John T. Gerlach</u> M.D. PHYSICIAN'S NAME (Type) <u>Baltimore 2 Maryland</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>				22d. LOCATION (City, town, or county) (State) <u>Balto. County, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Rd., Towson 4, Md.</u> ADDRESS						24a. REC'D BY REGISTRAR <u>SEP 28 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kahl</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G248 9-11-59 et

09951

09979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 Shade Ave</u>		d. STREET ADDRESS <u>2509 Elmore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mammie</u> First <u>Kahn</u> Middle Last		4. DATE OF DEATH Month <u>9-</u> Day <u>8-</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac</u>		14. MOTHER'S MAIDEN NAME <u>Tellie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Isadore Kahn - Anne</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 7</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.		DATE SIGNED <u>Sept 8, 59</u>	
ACTUAL SIGNATURE <u>Walter Bakal</u> M.D.		ADDRESS (Street, city or town, state) <u>3600 Lochearn Dr.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Windsor Hill Rd</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc - 2100 Eutaw Place</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 9 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

00001

STANDARD OF WEIGHTS & MEASURES

CERTIFICATE OF ANALYSIS

00002

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "analysis" and "sample" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 57 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEPHEN Middle J Last KEBER		4. DATE OF DEATH Month SEPTEMBER Day 22 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER KEBER		14. MOTHER'S MAIDEN NAME MARY PRUSKI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 219-16-8319	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO (b) BRONCHOGENIC CARCINOMA, LEFT UPPER LUNG METASTATIC CARCINOMA, PERIBRONCHIAL AND SUPRA- CLAVICULAR LYMPH NODES, LEFT ADRENAL AND BRAIN (c) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgical Absence, right testis INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27 , 19 59 , to September 22, 1959 , and that death occurred at 3:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTIMORE 18, MD, FT. HOWARD DIV. DATE SIGNED 9/23/59 ACTUAL SIGNATURE John W. Crawford M.D. PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm S Fialkowski		24a. REC'D BY REGISTRAR SEP 24 '59	
24b. REGISTRAR'S SIGNATURE C. J. Kraus			

2007 Eastern Ave Balto 31 Md

STATE OF NEW YORK

IN SENATE

JANUARY 1908

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED MAY 10, 1907

AND

REPORT

ON THE

LANDS

OF THE STATE

AND

ON THE

LANDS

OF THE STATE

AND

IN RESPONSE TO A RESOLUTION PASSED MAY 10, 1907

AND

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN

RESPONSE TO A RESOLUTION PASSED MAY 10, 1907

AND

REPORT ON THE LANDS OF THE STATE

AND

ON THE LANDS OF THE STATE

1908

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED MAY 10, 1907

AND

REPORT

ON THE

LANDS OF THE STATE

AND IN RESPONSE TO A RESOLUTION PASSED MAY 10, 1907

AND

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

1908

IN RESPONSE TO A RESOLUTION PASSED MAY 10, 1907

AND

09981

CERTIFICATE OF DEATH

09953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>803 Fifth Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W. King</u> Last <u>SR.</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>low ball beam</u>	9. AGE (In years last birthday) yrs. <u>67</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Melvin W. Marshall</u>		Address <u>803 5th Ave. Lansdowne, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 502.1 DUE TO <u>Chronic Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rev. years</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Poor Nutritional State</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 14, 1959</u> to <u>Sept. 28, 1959</u> , that I last saw the deceased alive on <u>Sept. 26, 1959</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florian P. Nadolski</u> M.D.		ADDRESS (Street, city or town, state) <u>2703 Hannant Ave. Keyte</u>	
PHYSICIAN'S NAME (Type) <u>Florian P. Nadolski</u>		DATE SIGNED <u>9/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Heights</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Brown</u>		ADDRESS <u>901 Solinus St.</u>	
24a. REC'D BY REGISTRAR <u>SEP 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

Name of Deceased		Date of Death	
John Doe		January 10, 1950	
Sex		Age	
Male		45 years	
Race		Place of Birth	
Caucasian		New York, U.S.A.	
Usual Residence		Address at Time of Death	
123 Main Street, Baltimore, Md.		123 Main Street, Baltimore, Md.	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Heart Disease	
Contributing Cause		Hypertension	
Period of Incubation		Time Elicited	
None		None	
Signature of Physician		Signature of Registrar	
John Doe, M.D.		Jane Smith, Registrar	
Date of Signature		Date of Signature	
January 10, 1950		January 10, 1950	
Place of Signature		Place of Signature	
Baltimore, Md.		Baltimore, Md.	
Official Seal		Official Seal	
None		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County		c. LENGTH OF STAY IN TB 16 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS Greenway Apts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convl. Home, 301 Chesapeake Av.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel W. Middle Kirk Last		4. DATE OF DEATH Month Sept. Day 21 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Kirk		14. MOTHER'S MAIDEN NAME Elizabeth Ashton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Homer Phillips, 2100 Cathedral Av./		Address Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Decompensative Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1959 to Sept 21, 1959 , that I last saw the deceased alive on Sept 21, 1959 , and that death occurred at 2 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore 12 DATE SIGNED 9/22/59 ACTUAL SIGNATURE Laurence C. Post M.D. PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.		24a. REC'D BY REGISTRAR SEP 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur A. Kline			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JOHN J. JONES		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15, 1945		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN J. H. Smith	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESSES None		18. SIGNATURE OF REGISTRAR None	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 810 Wildwood Parkway							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trailer Camp, Francis Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) EVANGELOS Krometis (Kromidis)				4. DATE OF DEATH Month Sept. Day 16 Year 1959							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1893		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Dry Cleaning Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Turkey		11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Christina ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If give war or data of service)				17. INFORMANT Mrs Eva Krometis Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Bradley King, Jr.				M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9/16/59			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-19-59		22c. NAME OF CEMETERY OR CREMATORY Greek Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR Leonard J. Ruck ADDRESS 5305 Harford Rd.						24a. REC'D BY REGISTRAR OAT SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

UNITED STATES
DEPARTMENT OF JUSTICE

RECEIVED

1

15-1-1964

15-1-1964

15-1-1964

15-1-1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09985

CERTIFICATE OF DEATH

Reg. Dist. No.

09958

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>401 Frederick Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nina E. Leister</i>		4. DATE OF DEATH <i>9/28 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/6/86</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>David Roelkey</i>		14. MOTHER'S MAIDEN NAME <i>Martha Renn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Wm. A. Leister</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>422.1</i> DUE TO <i>Marked Arterio-sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 1950, to <i>Sept 18</i> , 1959, that I last saw the deceased alive on <i>9/28</i> , 1959, and that death occurred at <i>4:20 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9376 Frederick Ave</i> DATE SIGNED <i>William P. Leister M.D.</i>			
ACTUAL SIGNATURE <i>William P. Leister</i>		PHYSICIAN'S NAME (Type) <i>William P. Leister</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/30/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Nabb + don</i>		ADDRESS <i>28</i>	
24a. REC'D BY REGISTRAR <i>OCT 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>William P. Leister</i>	

100000

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09959

09986

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 13yr9mth2dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Leonard Last Leonard				4. DATE OF DEATH Month September Day 5 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Leonard				14. MOTHER'S MAIDEN NAME Tillie Yost			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NO			
17. INFORMANT Records; Spring Grove State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio-sclerotic C.V.D. DUE TO (c) and 5 days						INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that I attended the deceased from August 31 , 19 59 , to September 5 , 19 59 , that I last saw the deceased alive on September 5 , 19 59 , and that death occurred at 1.20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrude J. Fleischmann M.D.				ADDRESS (Street, city or town, state) Spring Grove State Hospital			
PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN				DATE SIGNED 9. 5. 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-7-59		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial	
22d. LOCATION (City, town, or county) Baltimore				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc				ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

TO HOSPITAL O
may be retained

TO FUNERAL DIR:
page 3 should be
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death of the decedent by a physician who has attended the decedent within the last 24 hours of the decedent's life, or by the hospital or attending physician.

OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and be filed with the death certificate.

Death: Page 4

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09987

CERTIFICATE OF DEATH

09960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMACOST NURSING HOME</u>		d. STREET ADDRESS <u>43 Franklin St.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>W.</u> Last <u>MARVELL</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Wynkoop</u>		14. MOTHER'S MAIDEN NAME <u>Emily Nippes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Alice Marvell Tower Farm New Britain Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-</u> DUE TO (c) <u>Renal Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1959</u> to <u>September 19, 1959</u> , that I last saw the deceased alive on <u>Sept 20, 1959</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2501 York Rd 9th fl</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u> <u>Towson Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>SEPT 24, 1959</u>	<u>USNAVAL ACADEMY</u>	<u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR & SONS</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline S. Hanks</u>

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>	
AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1900</i>	
PLACE OF BIRTH <i>Baltimore, Md</i>		OCCUPATION <i>Teacher</i>	
MARITAL STATUS <i>Married</i>		DATE OF MARRIAGE <i>Jan 1 1925</i>	
NAME OF SPOUSE <i>Jane Doe</i>		PLACE OF MARRIAGE <i>Baltimore, Md</i>	
DATE OF DEATH <i>Jan 20 1945</i>		TIME OF DEATH <i>10:30 AM</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MEDICAL HISTORY <i>None</i>		PRESENT ILLNESS <i>None</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
DATE <i>Jan 20 1945</i>		TIME <i>10:30 AM</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09961

09988

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr4mth8dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
		f. STREET ADDRESS 205 Garden Ridge Rd.	
3. NAME OF DECEASED (Type or print) Bernardine X Catherine X Masters		4. DATE OF DEATH Month Sept. Day 14 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theodore Braun		14. MOTHER'S MAIDEN NAME Elizabeth Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Damage & Coronary Stenosis (c) Severe Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH Several days Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 11, 1959 to Sept. 14, 1959 , that I last saw the deceased alive on SEPT 13, 1959 , and that death occurred at 1:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Anthony S. Garofano M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-14-59	
PHYSICIAN'S NAME (Type) ANTHONY S. GAROFANO		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) A.A. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE SEP 16 '59	
		24b. REGISTRAR'S SIGNATURE Catharine E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1910
U.S. DEPT. OF JUSTICE
RECEIVED
JAN 10 1910
U.S. DEPT. OF JUSTICE



1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF DEATH NEW YORK	
3. DATE OF DEATH JAN 10 1910		4. TIME OF DEATH 10:00 AM	
5. SEX Male		6. AGE 30	
7. OCCUPATION Clerk		8. MARITAL STATUS Single	
9. COLOR White		10. BUILD Medium	
11. HAIR Brown		12. EYES Blue	
13. SKIN Fair		14. TENDRILS None	
15. DENTAL None		16. TATTOO None	
17. SCARS None		18. OTHER MARKS None	
19. CAUSE OF DEATH Disease		20. MANNER OF DEATH Natural	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John D. Smith	
23. SIGNATURE OF DOCTOR Dr. J. K. Brown		24. SIGNATURE OF MINISTER Rev. A. B. White	
25. SIGNATURE OF CORONER Coroner J. L. Green		26. SIGNATURE OF JURY Jury members	
27. SIGNATURE OF JURY Jury members		28. SIGNATURE OF JURY Jury members	
29. SIGNATURE OF JURY Jury members		30. SIGNATURE OF JURY Jury members	
31. SIGNATURE OF JURY Jury members		32. SIGNATURE OF JURY Jury members	
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69. SIGNATURE OF JURY Jury members		70. SIGNATURE OF JURY Jury members	
71. SIGNATURE OF JURY Jury members		72. SIGNATURE OF JURY Jury members	
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81. SIGNATURE OF JURY Jury members		82. SIGNATURE OF JURY Jury members	
83. SIGNATURE OF JURY Jury members		84. SIGNATURE OF JURY Jury members	
85. SIGNATURE OF JURY Jury members		86. SIGNATURE OF JURY Jury members	
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89. SIGNATURE OF JURY Jury members		90. SIGNATURE OF JURY Jury members	
91. SIGNATURE OF JURY Jury members		92. SIGNATURE OF JURY Jury members	
93. SIGNATURE OF JURY Jury members		94. SIGNATURE OF JURY Jury members	
95. SIGNATURE OF JURY Jury members		96. SIGNATURE OF JURY Jury members	
97. SIGNATURE OF JURY Jury members		98. SIGNATURE OF JURY Jury members	
99. SIGNATURE OF JURY Jury members		100. SIGNATURE OF JURY Jury members	

100-10-10

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09962

09989

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Merenbloom</u> Last <u>Merenbloom</u>		4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>optometrist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>1917-17 mo.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperpyrexia</u> DUE TO <u>603x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Pyelonephritis</u> DUE TO <u>Urinary stricture</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>17 days +</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 2</u> , 19 <u>59</u> , to <u>Sept. 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 6</u> , 19 <u>59</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Isidore Turk, M.D.</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp, Catonsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Isidore Turk, M.D.</u>		DATE SIGNED <u>M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookside</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Levenson Bros Inc</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>	
ADDRESS <u>176 N. North Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09963

09990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2622 Gwynndale Avenue				d. STREET ADDRESS 2622 Gwynndale Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Anna C. Messick				4. DATE OF DEATH Sept. 10, 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10'26'1899	
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Krammer Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gus C. Messick				14. MOTHER'S MAIDEN NAME Hattie Larmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-03-2913		INFORMANT Address Mrs. Emma Willing 4001 Cranston Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) HYPERTENSION DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1958 to SEPT 1959 , that I last saw the deceased alive on Sept 4th 1959 , and that death occurred at 7 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lee J. Volenick		M.D. 4710 Liberty Heights Ave ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type) Lee J. Volenick		M.D. 4710 Liberty Heights Ave.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9'13'59		22c. NAME OF CEMETERY OR CREMATORY Bivalve Meth. Church Cem.		22d. LOCATION (City, town, or county) (State) Bivalve, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR SEP 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. King			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 DUNDALK 22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1827 EAST AVENUE				d. STREET ADDRESS 1827 EAST AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle Last MICKLISH				4. DATE OF DEATH Month SEPT. Day 12 , Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1914	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) beef boner		10b. KIND OF BUSINESS OR INDUSTRY Geotze's Meat		11. BIRTHPLACE (State or foreign country) Ellwood City, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Constantine Micklish				14. MOTHER'S MAIDEN NAME Ursula Kibert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 200-01-1382		17. INFORMANT Address Mrs. Julianna Micklish same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knead	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to funeral, cremation or removal.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9965

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Farm - Franklinville, off Reynolds Rd.			d. STREET ADDRESS Ellicott City 74 College Ave. 13X-2 6502 Harmon Avenue		
3. NAME OF DECEASED (Type or print) WILLIAM HARRY MILLER			4. DATE OF DEATH September 25 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1915		9. AGE (In years last birthday) 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) D. C.	
13. FATHER'S NAME Frederick W. Miller			14. MOTHER'S MAIDEN NAME Maud V. Von Schmeide		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-05-2976		17. INFORMANT Mrs. Virginia A. Miller - 74 College Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Carbon Monoxide intoxication 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W. Bradley King, Jr.		M.D. W. Bradley King, Jr., M.D.		DATE SIGNED 9/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
23. FUNERAL DIRECTOR John J. Lickner & Sons - Baltimore		24a. REC'D BY REGISTRAR DATE SEP 30 '59		24b. REGISTRAR'S SIGNATURE Arthur A. House	

MEDICAL CERTIFICATION

2

2

RECEIVED
FBI

1

1

Handwritten signature or initials

SEP 10 1964

SEP 10 1964

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Items 18-20 Film 249 9-MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek (19)				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 7334 Waldman, Sparrows Point				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County Jail					a. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOHN Last MILLER					4. DATE OF DEATH Month September Day 19 Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1929		9. AGE (In years last birthday) 30 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter J. Miller					14. MOTHER'S MAIDEN NAME Anna Rebar				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WWII		16. SOCIAL SECURITY NO. 175-20-6868		17. INFORMANT John Miller		Address 64 Willow Spring Road Baltimore 22, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication 874.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) paraldehyde poisoning DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Ingested paraldehyde						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9/19/59 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Balto. Co. Jail		20f. (City or town) (County) (State) Towson Baltimore Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>W. V. Lovitt</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/19/59				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/59		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		22d. LOCATION (City, town, or country) (State) Bel Air, Maryland			
23. FUNERAL DIRECTOR ADDRESS Walter Brooks Bradley, Inc., Dundalk 22					24a. REC'D BY REGISTRAR SEP 22 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneaf</i>		

03008

03008

THE
FEDERAL
BUREAU OF
INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE DIRECTOR, FBI
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The remainder of the document contains several paragraphs of text that are illegible due to extreme blurriness and poor image quality. Some fragments of text are visible, such as "The following information was obtained from a review of the files of the [illegible] and [illegible] offices." and "It was determined that [illegible] had been in contact with [illegible] on [illegible] and [illegible]."]

09993 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY **Baltimore**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN **Baltimore**HOSPITAL OR
INSTITUTION OR
STREET ADDRESS**2603 Royal Oak Avenue**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland**COUNTY **Baltimore**CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN **Baltimore**STREET
ADDRESS(If rural give location)
2603 Royal Oak Avenue3. NAME OF
DECEASED:
(Type or Print)

(First)

EDWARD

(Middle)

ESAU

(Last)

MINOR

4. DATE

(Month)

(Day)

(Year)

OF
DEATH: **September****27 19 59**

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.**Male****White****Widowed****May****June 15, 1884****75**10a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if retired:10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?**Special Representative****American Express****Marriottsville, Md.****USA**

13. FATHER'S NAME:

George C. Minor

14. MOTHER'S MAIDEN NAME:

Lucy Shakelford Smith15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)**No**

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Alice M. Kachadourian-2603 Royal Oak Ave.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between
Onset And Death**1 week****5 years**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
office bldg., etc.)
OF
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURY

m.

INJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from **Jan. 2, 1946**, to **Sept. 27, 1959**, that I last saw the deceasedalive on **Sept. 27, 1959**, and that death occurred at **1:10 Pm.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

Burial**10/1/1959****Woodlawn Cemetery****Woodlawn****Maryland**DATE RECD BY LOCAL
REGISTER **SEP 30 1959**

REGISTRAR'S SIGNATURE

Arthur H. Thomas

24. FUNERAL DIRECTOR

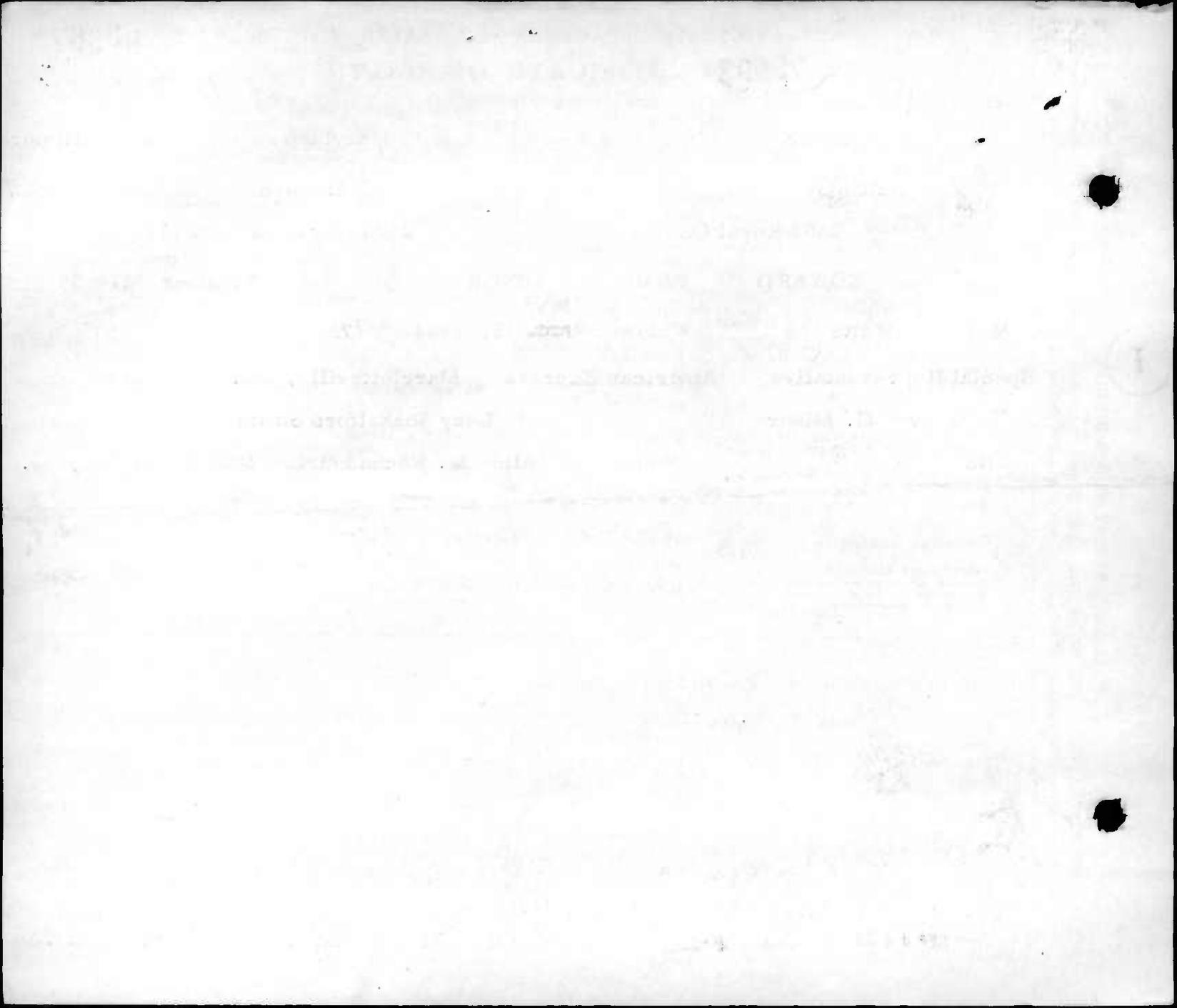
ADDRESS

Ellsworth Armacost-4600 Liberty Hgts. Av

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

0999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05968

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 537 Edgar Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex		d. STREET ADDRESS 537 Edgar Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) George William Moore		4. DATE OF DEATH 9 27 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-1906		9. AGE (in years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days 9 27		IF UNDER 24 HRS. Hours Min. 19 59							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bus Business		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel A Moore		14. MOTHER'S MAIDEN NAME Alvina Hays		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-1601		17. INFORMANT Melched Moore		Address Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED							
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				Address (Street, city, town, or county) Baltimore, Md.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-30-59				22c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR Henry Grunski				ADDRESS 1407 Eastern Ave 21				24a. REC'D BY REGISTRAR DATE SEP 30 '59				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus											

MEDICAL CERTIFICATION

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 248 9-25-59 ams									
09899									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09969									
1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 53		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Barry Road					d. STREET ADDRESS 1906 Barry Road				
3. NAME OF DECEASED (Type or print) First FREYA Middle MUELLMER Last MUELLMER					4. DATE OF DEATH Month Sept Day 3 Year 1959				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 13 1905 54		9. AGE (In years lost birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Switzerland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Don't know					14. MOTHER'S MAIDEN NAME Don't know				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. ---		INFORMANT Address Theron Whited 1906 Barry Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203x Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Myeloma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 Mos. + 1 mos.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 2, 1959 to Sept 3, 1959 that I last saw the deceased alive on Sept 3, 1959 , and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1801 Eutaw Place, Baltimore 17, Maryland DATE SIGNED ACTUAL SIGNATURE Lester Lebo PHYSICIAN'S NAME (Type) LESTER LEBOW, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Sept 5/59		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge			22d. LOCATION (City, town, or county) (State) Howard Co		
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road					24a. REC'D BY REGISTRAR DATE SEP 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines		

00000

CERTIFICATE OF DEATH

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09995

CERTIFICATE OF DEATH

09970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>436 Old Trail</u>				d. STREET ADDRESS <u>436 Old Trail</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret M. Murphy</u>				4. DATE OF DEATH Month Day Year <u>Sept. 26 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7 1883</u>	
9. AGE (In years, lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alexander Mc Carthy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Mc Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>BEATRICE M. MURPHY, 436 Old Trail</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DISEASE CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Branchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary edema</u> (c) <u>arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>Sept 26, 1959</u> , that I last saw the deceased alive on <u>Sept 25, 1959</u> and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>Baltimore, Md.</u> DATE SIGNED <u>9/28/59</u>							
ACTUAL SIGNATURE <u>George T. Gilmore</u> M.D.				PHYSICIAN'S NAME (Type) <u>GEORGE T. GILMORE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Supple Bros</u> ADDRESS <u>7110 Belair Rd</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09996

CERTIFICATE OF DEATH

Reg. Dist. No.

09971

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 77 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle L. Last MYERS		4. DATE OF DEATH Month September Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1921
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 37 Days 37 Hours 37 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY (Trucking Tractor)	
11. BIRTHPLACE (State or foreign country) Westminster, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Myers		14. MOTHER'S MAIDEN NAME Mattie Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 212-16-4379	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Balto. Md. Fort Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) METASTATIC SQUAMOUS CELL CARCINOMA, SKIN OF ABDOMEN, THIGHS AND BACK (c) 191.8		INTERVAL BETWEEN ONSET AND DEATH RECENT 21 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I (a) . SURGICAL ABSENCE, PENIS. EMACIATION. Amputation of Penis. Operation 9/9/58 Doctor's Hospital		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4 , 19 59 , to September 19, 59 , and that death occurred at 2:45 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. VAH, BALTO 18, MD. FT. HOWARD DIV. DATE SIGNED 9/21/59	
ACTUAL SIGNATURE DAVID A. OUESLER, M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-59	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Chok, Blight, Inc. 6009 Harford Rd., Balto, Md.		24a. REC'D BY REGISTRAR SEP 24 '59	
24b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

00001

CERTIFICATE OF DEATH

00002

1950

1950

Bellevue (32)

77 yrs

Long Island

1000 Gregory Drive

Verona Annapolis Hospital

1000 Gregory Drive

1000 Gregory Drive

October 3, 1951

October 3, 1951

U. S. A. (Doctor's Name)

U. S. A. (Doctor's Name)

Local City

Local City

1000 Gregory Drive, Ver. Annapolis, Md. 20704

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

1000 Gregory Drive

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09997

CERTIFICATE OF DEATH

Reg. Dist. No.

19972

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 19 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore (30) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3001.4 d. STREET ADDRESS 1604 Clarkson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle R Last NEISSER		4. DATE OF DEATH Month September Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1890
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower		10b. KIND OF BUSINESS OR INDUSTRY Glass Factory	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Neisser		14. MOTHER'S MAIDEN NAME Emma M.; Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-05-9723	
17. INFORMANT Clin. Rec. V.A.H., Balto., Md., Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTUM WITH METASTASES DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 154X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: Exploratory Laparotomy and Transverse Colostomy 3/17/59. Inoperable adenocarcinoma of rectum filling pelvis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
20a. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1959 to September 1, 1959 and that death occurred at 8:03A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD., FORT HOWARD DIV. 9/1/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTO 18, MD., FORT HOWARD DIV.	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO 18, MD., FT. HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Evans		ADDRESS 1400 S. Charles St., Balto., Md.	
24a. REC'D BY REGISTRAR SEP 3 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MAIN ROOM 210

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation	
James Nelson		June 2, 1890		Male		White		Single		None	
Place of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
Glass Factory, Baltimore, Maryland		September 1, 1939		10:30 AM		1001 Chapman Street, Baltimore, Maryland		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Entry		Date of Filing		Date of Issuance		Date of Distribution		Date of Archiving	
September 1, 1939		September 1, 1939		September 1, 1939		September 1, 1939		September 1, 1939		September 1, 1939	

Operation: Laboratory, Laboratory and Forensic Chemistry, 210/39.
 Inoperable adenocarcinoma of rectum, filling rectum.

NAME OF DECEASED: JAMES NELSON
 DATE OF BIRTH: JUNE 2, 1890
 SEX: MALE
 RACE: WHITE
 MARRIAGE: SINGLE
 OCCUPATION: NONE
 PLACE OF BIRTH: GLASS FACTORY, BALTIMORE, MARYLAND
 DATE OF DEATH: SEPTEMBER 1, 1939
 TIME OF DEATH: 10:30 AM
 PLACE OF DEATH: 1001 CHAPMAN STREET, BALTIMORE, MARYLAND
 CAUSE OF DEATH: HEART DISEASE
 MANNER OF DEATH: NATURAL
 SIGNATURE OF PHYSICIAN: [Signature]
 SIGNATURE OF REGISTRAR: [Signature]
 SIGNATURE OF INFORMANT: [Signature]
 SIGNATURE OF DECEASED: [Signature]
 SIGNATURE OF BURIAL OFFICER: [Signature]
 SIGNATURE OF UNDERTAKER: [Signature]
 DATE OF REPORT: SEPTEMBER 1, 1939
 DATE OF ENTRY: SEPTEMBER 1, 1939
 DATE OF FILING: SEPTEMBER 1, 1939
 DATE OF ISSUANCE: SEPTEMBER 1, 1939
 DATE OF DISTRIBUTION: SEPTEMBER 1, 1939
 DATE OF ARCHIVING: SEPTEMBER 1, 1939

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09998

CERTIFICATE OF DEATH

09973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11yr2mth23dys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 230 West 19th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loretta		4. DATE OF DEATH September 15 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1883
		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Nolan		14. MOTHER'S MAIDEN NAME Bridget Coyne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Gangrene of right foot			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 28, 19 59 to Sept. 15, 19 59 , that I last saw the deceased alive on Sept. 15, 19 59 , and that death occurred at 4:25 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-15-59	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
burial		Sept 16/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cathedral		13cells 24-MD	
23. FUNERAL DIRECTOR'S SIGNATURE Steward Momen		24a. REC'D BY REGISTRAR SEP 16 59 DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

CERTIFICATE OF DEATH

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See Ch. 10

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

09999

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u> 69x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forlign Nursing Home</u>				d. STREET ADDRESS <u>60 Thayer St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Sara Oppenheim</u>				4. DATE OF DEATH Month Day Year <u>Sept 19 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH (M) <u>Feb. 24, 1868</u> 94 yrs.	
9. AGE (In years last birthday) <u>94</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Not known</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Mrs H J. Windesheim</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X carcinoma of stomach with metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 26, 1959</u> to <u>19 Sep 1959</u> that I last saw the deceased alive on <u>18 Sep 1959</u> , and that death occurred at <u>7:59 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd</u> DATE SIGNED <u>19 Sep 59</u>							
ACTUAL SIGNATURE <u>Paul H Royse</u> M.D.				DATE SIGNED <u>19 Sep 59</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>				ADDRESS <u>Pikesville 8 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kensico Cemetery</u>		22d. LOCATION (City, town, or county) <u>Valhalla N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eutaw Place</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1003

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

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1003

10000

CERTIFICATE OF DEATH

09975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Home Nursing Home		d. STREET ADDRESS 535 Kingston Road	
3. NAME OF DECEASED (Type or print) First George Middle Paulus Last Paulus		4. DATE OF DEATH Month September Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 5, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce dealer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Paulus		14. MOTHER'S MAIDEN NAME Dont know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. John Paulus 535 Kingston Road-20	
17. INFORMANT John Paulus 535 Kingston Road-20		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC PAROXY - UNSTABLE 422.1 DUE TO DISEASE - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIARRHOEA - SEVERE DUE TO (c) FRAGILE CEF & WID (OLD)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/9 , 19 59 , to 9/23 , 19 59 , that I last saw the deceased alive on 9/23 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John H. Shaw M.D.		5350 E. MARYLAND AVE. 9/25/59	
PHYSICIAN'S NAME (Type) John H. Shaw		M.D. 28, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1880

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. PLACE OF DEATH	
JAMES M. JONES		Male		35		April 15, 1880		City of Baltimore	
6. CAUSE OF DEATH		7. PLACE OF BIRTH		8. OCCUPATION		9. MARITAL STATUS		10. COLOR	
Typhoid fever		City of Baltimore		Clerk		Single		White	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF DECEASED		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
16. NAME OF HOSPITAL		17. NAME OF CLINIC		18. NAME OF DISPENSARY		19. NAME OF PHARMACY		20. NAME OF STORE	
St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital	
21. NAME OF CHURCH		22. NAME OF CEMETERY		23. NAME OF FUNERAL HOME		24. NAME OF BURIAL PLACE		25. NAME OF INTERMENT	
St. Mary's Church		St. Mary's Cemetery		St. Mary's Funeral Home		St. Mary's Burial Place		St. Mary's Interment	
26. NAME OF MINISTER		27. NAME OF CLERGYMAN		28. NAME OF DEACON		29. NAME OF CHORIST		30. NAME OF ORGANIST	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
31. NAME OF SINGER		32. NAME OF ORGANIST		33. NAME OF CHORIST		34. NAME OF DEACON		35. NAME OF CLERGYMAN	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
36. NAME OF DECEASED		37. NAME OF DECEASED		38. NAME OF DECEASED		39. NAME OF DECEASED		40. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
41. NAME OF DECEASED		42. NAME OF DECEASED		43. NAME OF DECEASED		44. NAME OF DECEASED		45. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
46. NAME OF DECEASED		47. NAME OF DECEASED		48. NAME OF DECEASED		49. NAME OF DECEASED		50. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
51. NAME OF DECEASED		52. NAME OF DECEASED		53. NAME OF DECEASED		54. NAME OF DECEASED		55. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
56. NAME OF DECEASED		57. NAME OF DECEASED		58. NAME OF DECEASED		59. NAME OF DECEASED		60. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
61. NAME OF DECEASED		62. NAME OF DECEASED		63. NAME OF DECEASED		64. NAME OF DECEASED		65. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
66. NAME OF DECEASED		67. NAME OF DECEASED		68. NAME OF DECEASED		69. NAME OF DECEASED		70. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
71. NAME OF DECEASED		72. NAME OF DECEASED		73. NAME OF DECEASED		74. NAME OF DECEASED		75. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
76. NAME OF DECEASED		77. NAME OF DECEASED		78. NAME OF DECEASED		79. NAME OF DECEASED		80. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
81. NAME OF DECEASED		82. NAME OF DECEASED		83. NAME OF DECEASED		84. NAME OF DECEASED		85. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
86. NAME OF DECEASED		87. NAME OF DECEASED		88. NAME OF DECEASED		89. NAME OF DECEASED		90. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
91. NAME OF DECEASED		92. NAME OF DECEASED		93. NAME OF DECEASED		94. NAME OF DECEASED		95. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
96. NAME OF DECEASED		97. NAME OF DECEASED		98. NAME OF DECEASED		99. NAME OF DECEASED		100. NAME OF DECEASED	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. CAUSE OF DEATH
7. PLACE OF BIRTH
8. OCCUPATION
9. MARITAL STATUS
10. COLOR
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF DECEASED
14. SIGNATURE OF CLERK
15. SIGNATURE OF REGISTRAR
16. NAME OF HOSPITAL
17. NAME OF CLINIC
18. NAME OF DISPENSARY
19. NAME OF PHARMACY
20. NAME OF STORE
21. NAME OF CHURCH
22. NAME OF CEMETERY
23. NAME OF FUNERAL HOME
24. NAME OF BURIAL PLACE
25. NAME OF INTERMENT
26. NAME OF MINISTER
27. NAME OF CLERGYMAN
28. NAME OF DEACON
29. NAME OF CHORIST
30. NAME OF ORGANIST
31. NAME OF SINGER
32. NAME OF ORGANIST
33. NAME OF CHORIST
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35. NAME OF CLERGYMAN
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98. NAME OF DECEASED
99. NAME OF DECEASED
100. NAME OF DECEASED

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Finland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. Rt 40 - Pulaski Highway		c. LENGTH OF STAY IN 1b Scene of accident Wm Jones Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Scene of accident Wm Jones Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EINO PEHKONEN		4. DATE OF DEATH Month September Day 15 Year 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1935	
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		11b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
12. BIRTHPLACE (State or foreign country) Finland		13. CITIZEN OF WHAT COUNTRY? Finland	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Miss E. Pehkonen	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Crushing injuries of chest and abdomen 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH PARTIAL			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by truck	
20c. TIME OF INJURY Month, Day, Year 3:03 a.m. 9/15/1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR William Cook, Inc.		24a. REC'D BY REGISTRAR SEP 22 '59	
24b. REGISTRAR'S SIGNATURE William & Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09977

10002

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5738 First Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Pfeiffer Last Pfeiffer		4. DATE OF DEATH Month Sept. Day 7 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1882
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Hettche		14. MOTHER'S MAIDEN NAME Christina Gonderman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Natalie Brown		Address 5738 First Ave. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Failure - Acute - DUE TO (b) Arterio-sclerotic Cardiovascular Disease DUE TO (c) Arterio-sclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/59 to 9/17/59 , that I last saw the deceased alive on 9/17/59 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1305 N. Francis Avenue DATE SIGNED James Frederick M.D.			
ACTUAL SIGNATURE James Frederick M.D.			
PHYSICIAN'S NAME (Type) James Frederick M. D. 1305 N. Francis Avenue			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/59	
22c. NAME OF CEMETERY OR CREMATORY Laudon Park Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR SEP 10 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05977

Name of Deceased John Herndon		Sex Male		Age 29	
Date of Death Sept. 10, 1922		Place of Death Home		Cause of Death Typhoid Fever	
Residence 5735 Enoch Avenue		Occupation None		Usual Place of Abode Home	
Manner of Death Natural		Signature of Physician James Frankfort, M.D.		Signature of Registrar Howard H. Roberts	
County Baltimore		City Baltimore		State Maryland	
Name of Informant Mrs. Natalie Brown		Relationship Wife		Address 1305 W. Enoch Avenue	
Signature of Informant		Signature of Registrar		Signature of Physician	

10003

CERTIFICATE OF DEATH

Reg. Dist. No.

09978

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Maryland d. STREET ADDRESS 550 Bourbon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Larry Middle Dennis Last Poole		4. DATE OF DEATH Month 9 Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/59
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR 1 Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cecil Edwards		14. MOTHER'S MAIDEN NAME Pearl Cleo Zachry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive atelectasis of both lungs 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malformation of brain and spinal cord; microgyria; hydrocephalus; Arnold- 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Child's Syndrome			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1959 , to Sept. 29, 1959 , that I last saw the deceased alive on 19 , and that death occurred at 6:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rosewood State Training School Box 188 Owings Mills, Maryland DATE SIGNED			
ACTUAL SIGNATURE Edward J. Mathews		PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/1/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		22d. LOCATION (City, town, or county) (State) Owings Mills Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline Sons Rustertown Md		24a. REC'D BY REGISTRAR OCT 15 1959	
24b. REGISTRAR'S SIGNATURE William J. Kiana			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1000232XV4

CERTIFICATE OF DEATH

1900

11-27-00

State of Maryland
County of Prince George's
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 27th day of November, 1900, at the residence of the deceased, I examined the body of one [Name], who had died at the residence of the deceased, and found that the same was dead, and that the death was caused by [Cause of Death].

Witness my hand and seal this 27th day of November, 1900.
[Signature]
Physician

Subscribed and sworn to before me this 27th day of November, 1900.
[Signature]
Notary Public

Attest:
[Signature]
Clerk of the Court

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09979

10004
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 117 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS Route 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Served As: First CLARENCE (NMI) Middle W. Purnell Last Purnell		4. DATE OF DEATH Month September Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Purnell		14. MOTHER'S MAIDEN NAME Mary Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) MW I		16. SOCIAL SECURITY NO. 217-09-1817	
17. INFORMANT Clin. Records, VAH Balto 18, Md., Fort Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT SIDE CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC RENAL DISEASE WITH NEPHROTIC SYNDROME			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from May 11 , 19 59 , to September 5 , 19 59 , and that death occurred at 11:58 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD. FT. HOWARD DIV. 9/6/59	
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.		VAH, BALTO 18, MD. FT. HOWARD DIV. 9/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/8/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REG'D BY REGISTRAR SEP 10 59	
ADDRESS 1808 N. Monroe Street Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE Arthur E. Evans	

Keywords: child abuse; child sexual abuse; child sexual exploitation; child sexual abuse investigation; child sexual abuse assessment

5424 J. Neurosci., September 24, 2008 • 28(39):5418–5424

4-2365-721

Thyridochlamys yezoensis n. sp.

1951. 1. 1.

© 2004

Received: 21/05/2018

Leaves: 2' long

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4-10-68

10005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville RD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville RD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gibbons Blvd.		d. STREET ADDRESS Gibbons Blvd.	
3. NAME OF DECEASED (Type or print) JAMES ROSS QUINN		4. DATE OF DEATH Month September Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1898
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio Corp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Quinn		14. MOTHER'S MAIDEN NAME Emma Sauble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 29th , 1959, to Sept. 16th , 1959, that I last saw the deceased alive on Sept. 16th , 1959, and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. X. Quinn		ADDRESS (Street, city or town, state) DATE SIGNED 1927 YORK RD, TIMONIUH, Md 9/18/59	
PHYSICIAN'S NAME (Type) MICHAEL KEVIN QUINN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 20, 1959	22c. NAME OF CEMETERY OR CREMATORY Weisburg Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Weisburg, Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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growth rate

Copyright Clearance Center

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Journal of Management Education

...A social.

Notes

(Faint, illegible text)

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abuse - 1137

Владимир, Алексей, Игорь, Андрей, Олег.

CERTIFICATE OF DEATH

Reg. Dist. No.

10006

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 89 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle M. Last RACHUBINSKI				4. DATE OF DEATH Month September Day 23 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 24, 1910	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 3 Days 1		11. IF UNDER 24 HRS. Hours 1 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Tile Setting		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Michael Rachubinski				14. MOTHER'S MAIDEN NAME Susannah Gorczewicz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W Yes WW II				16. SOCIAL SECURITY NO. 216-07-2555			
17. INFORMANT Clinical Records, Baltimore, Md. Fort Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LAENNEC'S CIRRHOSIS DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inactive Pulmonary Tuberculosis, Left 002X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 26 , 19 59 , to September 23 , 19 59 , and that death occurred at 1:00A AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTIMORE MD, FT. HOWARD DIV. DATE SIGNED 9/23/59 ACTUAL SIGNATURE John W. Crawford PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTIMORE MD, FT. HOWARD DIV. 9/23/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-26-59			
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond I. Kaczorowski				24a. REC'D BY REGISTRAR SEP 30 '59			
ADDRESS 2525 Fleet St. Balto. Md.				24b. REGISTRAR'S SIGNATURE Arthur J. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(24)

SS Dave

Department of Information Honolulu

H.

JOHN

SS Dave

File Section

Michael Macdonald

100-0000

HERBERT KILGUS

LAWSON'S CIRCULARS

Investigative Laboratory Honolulu, Hawaii

June 20

RECEIVED

JOHN W. CHAPMAN, M.D.

Helplessly Unconscious

Received at Honolulu 2:30 P.M. June 20, 1944

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10007

CERTIFICATE OF DEATH

09983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holly Hill Manor Nurs. Ho.				d. STREET ADDRESS 643 Sussex Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SARA Middle - Last REISS				4. DATE OF DEATH Month Sept. Day 1 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1891		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 67 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rtd)		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James McLaughlin				14. MOTHER'S MAIDEN NAME Sarah Rhodenburger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address O. H. Bair & Co.-1820 Chestnut St., Phila., Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis C-V-R. Dis. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion, Coronary A.T.S. DUE TO (c) 1 yr.							INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 19 56 to Sept 1 19 59 , that I last saw the deceased alive on August 30 19 59 , and that death occurred at 1:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6201 York Rd DATE SIGNED 9/1/59							
ACTUAL SIGNATURE Dee S. Con Jr M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/1/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cem.		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balt.				24a. REC'D BY REGISTRAR SEP 3 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kinn	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09984

10008

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase				c. LENGTH OF STAY IN 1b Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 16 Box 240 Ebenezer Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Richardson				4. DATE OF DEATH Month Sept. Day 12, Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Robertson				14. MOTHER'S MAIDEN NAME Unknown Dunty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. Harry R. Richardson Rt. 16 Box 240 20			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General infection Bed sores DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chase	(County) Md.		(State)	
21. I certify that I attended the deceased from July 15, 1959 to Sept 12, 1959 , that I last saw the deceased alive on Sept 10, 1959 , and that death occurred at 8 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Michael J. Grossfeld		M.D. 5402 Belair Rd. Balto 6 Md.		DATE SIGNED			
PHYSICIAN'S NAME (Type) MICHAEL J. GROSSELD M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		22d. LOCATION (City, town, or county) Chase, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lewahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR SEP 16 59	24b. REGISTRAR'S SIGNATURE Arthur J. Thomas

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

10009

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 27 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELBERT Middle --- Last RICKS		4. DATE OF DEATH Month September Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 25, 1914
9. AGE (In years lost birthday) yrs. 45		10. UNDER 1 YEAR Months 45 Days 45 Hours 45 Min.	11. UNDER 24 HRS. Months 45 Days 45 Hours 45 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Nash Co., N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Daniel Ricks	
14. MOTHER'S MAIDEN NAME Leora Todd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 243-20-1960		17. INFORMANT Clinical Records VAH, Balto, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND ASPIRATION PNEUMONIA DUE TO SQUAMOUS CELL CARCINOMA, URINARY BLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE SUPPURATIVE PERITONITIS (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operations: 9/14/59 1. Ureteroileostomy, bilateral. 2. Cutaneocystostomy. 3. Ileocystostomy.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 24, 1959 to September 20, 1959 , and that death occurred at 9:40 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter J. Pijanowski</i>		ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO., MD. FORT HOWARD DIVISION 9/22/59	
PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		VAH, BALTO., MD. FORTHOWARD DIVISION 9/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808-10 N. Monroe St. Balto Md.		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

County of

State of

Age

(S)

Residence

Sex

Color

Place of birth

Date of birth

Dec 20 1900

John Doe

John Doe

John Doe

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U. S. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G248 9-14-59 et

10010

CERTIFICATE OF DEATH

09986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 PARK DRIVE</u>		d. STREET ADDRESS <u>101 PARK DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>E.</u> Last <u>RICKTOR</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3, 1879</u>
9. AGE (In years last birthday) <u>79 8/10</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>CHARLES HAUPT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John Henry Ricktor - 101 Park Drive</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Sept.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 4</u> , 19 <u>59</u> , and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo J. Gaver</u> M.D.		ADDRESS (Street, city or town, state) <u>1 Malldow Hill Rd.,</u> DATE SIGNED <u>9/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>		<u>Baltimore 29, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>8-8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home, Catonsville, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10011

CERTIFICATE OF DEATH

Reg. Dist. No.

09987

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle H. Last RINEHART		4. DATE OF DEATH Month September Day 5 Year 1959	
5. SEX M Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/79
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Rinehart		14. MOTHER'S MAIDEN NAME Lena Crammer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 10/14/98-2/16/99		16. SOCIAL SECURITY NO. 717-07-8842	
17. INFORMANT Clin. Rec. VAH, Balto, 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY INFARCTION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 1 DAY UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 26, 1959 , to September 5, 1959 , and that death occurred at 6:00 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur T. Faulk, MD		ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD. FORT HOWARD DIV. 9/5/59	
PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.		VAH, BALTO 18, MD. FORT HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Chenoweth Funeral Home		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS 36 & Chestnut Avenue Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE Arthur T. Faulk	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1901

DATE OF DEATH

PLACE

TO DATE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10012

CERTIFICATE OF DEATH

09988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 FOREST AVE.		d. STREET ADDRESS 1118 FOREST AVE	
3. NAME OF DECEASED (Type or print) First MANIE Middle H. Last ROBERTS		4. DATE OF DEATH Month SEPT. Day 3 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME HENRY H. DIXON		14. MOTHER'S MAIDEN NAME SUSANA E. LEFTLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Miss Eleanor Roberts		Address 118 FOREST AVE.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardis 442X DUE TO (b) Vasculen Renal Distensio Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) With uremia Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1958 to Sept 3, 1959 , that I last saw the deceased alive on Sept 3, 1959 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Paul Byerly M.D.		ADDRESS (Street, city or town, state) 3033 W North A DATE SIGNED	
PHYSICIAN'S NAME (Type) M Paul Byerly		Balto 18 med	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-6-59	22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery	22d. LOCATION (City, town, or county) (State) Ellicott City Md.
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home - Catonsville Md ADDRESS		24a. REC'D BY REGISTRAR SEP 9 59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1901		10:00 AM		J. Smith		A. Jones		B. Brown	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology	
New York		Jan 1, 1856		Jan 1, 1901		Jan 1, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Radiology		Date of Histology	
Home		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Radiology		Date of Histology	
Heart Disease		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Radiology		Date of Histology	
Home		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Radiology		Date of Histology	
Heart Disease		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
o. COUNTY Baltimore MARYLAND				o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 6504 Hartwait Street			
3. NAME OF DECEASED (Type or print) First Middle Last Harvey Raymond Robertson				4. DATE OF DEATH Month Day Year 9 18 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/58		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harvey Raymond Robertson				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		INFORMANT Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pressure ulcer (thoracic area) DUE TO (c) Arnold Chiari Syndrome							INTERVAL BETWEEN ONSET AND DEATH 16 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arnold Chiari Syndrome							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/11/59 19, to 9/18/59 19, that I last saw the deceased alive on 9/18/59 19, and that death occurred at 1:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry S. Butler M.D.				ADDRESS (Street, city or town, state) Owings Mills, Md 9/18/59 DATE SIGNED			
PHYSICIAN'S NAME (Type) ---							
22a. BURIAL, CREMATION, REINTERMENT (Specify) Buried		22b. DATE THEREOF 9-21-59		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Belair Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James J. Brudzinski ADDRESS 14077 Harbor Dr				24a. REC'D BY REGISTRAR DATE SEP 22 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kenna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10014

CERTIFICATE OF DEATH

Reg. Dist. No.

09990

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA 02-50-2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House 14 Pine St</u>		d. STREET ADDRESS <u>Broadway</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick A Roder</u>		4. DATE OF DEATH Month Day Year <u>9 10 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-73</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster WAGNERS PL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A.</u>		14. MOTHER'S MAIDEN NAME <u>Eva M.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family: June</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>70a</u> <u>153 (7)</u> <u>153 (3)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-27</u> , 19 <u>59</u> , to <u>9-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-10</u> , 19 <u>59</u> , and that death occurred at <u>2:25</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		DATE SIGNED <u>9-10-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>130 E. Foot Car</u>		22b. DATE THEREOF <u>9-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Locust Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baeth</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Hume</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESSES <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF REGISTRAR <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
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28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
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64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
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1. Name of Deceased
2. Sex
3. Age
4. Date of Death
5. Time of Death
6. Place of Death
7. Cause of Death
8. Manner of Death
9. Place of Birth
10. Occupation
11. Marital Status
12. Education
13. Previous Illness
14. Medical History
15. Survival of Others
16. Signature of Deceased
17. Signature of Witnesses
18. Signature of Physician
19. Signature of Registrar
20. Signature of Clerk
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101. Signature of Jury
102. Signature of Jury

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09900

CERTIFICATE OF DEATH

Reg. Dist. No. 09991

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sundalk</u>				c. LENGTH OF STAY IN 1b <u>14 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>170 Chestnut Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Rodgers</u> Middle <u></u> Last <u></u>				4. DATE OF DEATH <u>September 19,</u> 19 <u>59</u> Month <u>September</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Clayton, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Henderson Saunders</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Sanders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		INFORMANT <u>Mrs. Pearl Mc Laughlin</u> Address <u>170 Chestnut Street</u>		17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>9/19/59</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>Sept 18/59</u> to <u>Sept 19/59</u> , that I last saw the deceased alive on <u>September 19/59</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>107 N. Main St.</u> DATE SIGNED <u>9/22/59</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waverly Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Jackson</u> ADDRESS <u>Federal Home Inc.</u>				24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Kinn</u>	

CERTIFICATE OF DEATH

1998

1998

MASSACHUSETTS DEPARTMENT OF HEALTH

100

100



10015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Clivedon Rd.				d. STREET ADDRESS 10 Clivedon Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle JOHNSON S. Last ROMANS				4. DATE OF DEATH Month SEP Day 14 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Johnson				14. MOTHER'S MAIDEN NAME Amelia Forman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. no		INFORMANT Mr. Alexander Romans - 10 Clivedon Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic heart disease DUE TO (b) few years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH few years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19.56 to 14 Sep, 1959 that I last saw the deceased alive on 17 Aug, 1959 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 808 Reisterstown Rd. Pikesville 8, Md. DATE SIGNED 14 Sep 59							
ACTUAL SIGNATURE Paul H Royse M.D.				DATE SIGNED 14 Sep 59			
PHYSICIAN'S NAME (Type) PAUL H ROYSE MD				ADDRESS Pikesville 8, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/17/59		22c. NAME OF CEMETERY OR CREMATORY Green Mount Crem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Sienkiewicz & Sons - Balt.				24a. REC'D BY REGISTRAR SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK
CERTIFICATE OF DEATH

1913

NOTED

11

10016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN Tb <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1407 Midvale Ave</i>		e. STREET ADDRESS <i>1407 Midvale Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Chester</i> Middle <i>Sadler</i> Last 4. DATE OF DEATH Month <i>Sept.</i> Day <i>22</i> Year <i>1959</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/7/98</i>
9. AGE (In years lost birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pressman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Printing</i>	11. BIRTHPLACE (State or foreign country) <i>md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Sadler</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Smith</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Marie E. Sadler</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.7 Ruptured Aneurysm Pulmonary Artery</i> DUE TO (b) <i>Artery</i> DUE TO (c) <i>Pulmonary Stenosis + Insufficiency</i> Congenital Aneurysm Pulmonary Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>all life</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/9</i> , 19 <i>57</i> , to <i>9/22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/4</i> , 19 <i>59</i> , and that death occurred at <i>6:45 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Eliot W. Johnson</i> M.D. <i>3432 Frederick Ave</i> <i>9/28/59</i> PHYSICIAN'S NAME (Type) <i>ELIOT W. JOHNSON MD</i> <i>Baltimore 29 MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>9/25/59</i>	<i>Cathedral</i>	<i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marie Math + son</i>		ADDRESS <i>28</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 28 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

CERTIFICATE OF DEATH

10018

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

10017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL OVERLEA</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7703 BELAIR RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADAM WILLIAM SCEPANIAK</u>		4. DATE OF DEATH Month Day Year <u>SEPT 4 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 24 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAVERN OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM SCEPANIAK</u>		14. MOTHER'S MAIDEN NAME <u>MARY NOVAKOWSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>15-40-2242</u>	
17. INFORMANT <u>ANNA G. SCEPANIAK</u>		Address <u>7703 BELAIR RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Disease, coronary artery disease,</u> (c) <u>coronary occlusion</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>16 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1, 1959</u> to <u>Sept. 4, 1959</u> that I last saw the deceased alive on <u>Sept 4, 1959</u> , and that death occurred at <u>9:10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Gessner</u>		ADDRESS (Street, city or town, state) <u>Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>John E. Gessner</u>		DATE SIGNED <u>9/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 8 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST STANIS LAUS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>DUNDACK AVE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Opffel Bros</u>		ADDRESS <u>7110 BELAIR RD</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Gessner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10018

CERTIFICATE OF DEATH

Reg. Dist. No.

09995

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SYLVESTER Middle P. Last SCOTT				4. DATE OF DEATH Month September Day 14 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler - Cook		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Sylvester Scott				14. MOTHER'S MAIDEN NAME Laura Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		INFORMANT Address Clin. Records, VAH, Balto. 18, Md. Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT (THROMBOSIS) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 DAYS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 12 1959 , to September 14 1959 and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John W. Crawford M.D. VAH, BALTO, 18, MD. FT. HOWARD DIVISION 9/14/59							
ACTUAL SIGNATURE John W. Crawford							
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 9/14/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE Arthur & Hans	
ADDRESS 1631 Druid Hill Ave., Balto Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10017 CERTIFICATE OF DEATH

Date of Death: 10/20/1917
 Place of Death: Baltimore
 Age: 2 years
 Sex: Male
 Race: White
 Cause of Death: Infantile Parotiditis
 Signature of Physician: [Signature]
 Signature of Registrar: [Signature]
 Date of Registration: 10/20/1917
 Place of Registration: Baltimore
 Name of Deceased: [Name]
 Date of Birth: [Date]
 Place of Birth: [Place]
 Name of Mother: [Name]
 Name of Father: [Name]
 Name of Registrar: [Name]
 Signature of Registrar: [Signature]
 Date of Registration: 10/20/1917
 Place of Registration: Baltimore

This certificate is a true and correct copy of the original as filed in the office of the Registrar of Deaths for the City and County of Baltimore, Maryland.
 Given under my hand and the seal of the Registrar of Deaths for the City and County of Baltimore, Maryland, this 20th day of October, 1917.
 [Signature]
 Registrar of Deaths

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10019

CERTIFICATE OF DEATH

Reg. Dist. No.

09996

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> <u>19 Harrison St. Essex</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ivy Hall Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Harrison St. Essex, Md.</u>		d. STREET ADDRESS <u>Long Beach</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>A</u> Last <u>SEIFERT</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harry Kepner</u> Address <u>RD 15 Box 319 Baltimore 20, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease, Abnormal Symp.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>current</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 - Hickory cot RD</u> DATE SIGNED <u>9/21/59</u> ACTUAL SIGNATURE <u>Joseph J. Cameron</u> M.D. <u>BALTO 4, Md</u> PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept. 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Harrisburg</u>		22d. LOCATION (City, town, or county) (State) <u>Harrisburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u> ADDRESS <u>1217 St. Paul St.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

2. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial transit permit. Then please remove further copies. Pages 1 and 2 should be filed with

VS A15 (4)
15M 9/58

Picked

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00934

DEATH OF NATURAL CAUSE I, the undersigned, being a duly qualified physician, do hereby certify that the above-named person died of a disease, injury, or violence, and that the cause of death was as stated above.		DEATH OF UNNATURAL CAUSE I, the undersigned, being a duly qualified physician, do hereby certify that the above-named person died of a disease, injury, or violence, and that the cause of death was as stated above.	
NAME OF DECEASED LAST NAME FIRST NAME MIDDLE NAME SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE AGE <input type="checkbox"/> YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS DATE OF BIRTH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		PLACE OF BIRTH STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> TOWNSHIP <input type="checkbox"/>	
OCCASION OF DEATH PLACE OF DEATH DATE OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		TIME OF DEATH <input type="checkbox"/> HOURS <input type="checkbox"/> MINUTES <input type="checkbox"/> SECONDS PLACE OF DEATH <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> OTHER <input type="checkbox"/>	
SIGNATURE OF PHYSICIAN NAME OF PHYSICIAN ADDRESS OF PHYSICIAN CITY <input type="checkbox"/> STATE <input type="checkbox"/>		SIGNATURE OF FUNERAL DIRECTOR NAME OF FUNERAL DIRECTOR ADDRESS OF FUNERAL DIRECTOR CITY <input type="checkbox"/> STATE <input type="checkbox"/>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10020

CERTIFICATE OF DEATH

Reg. Dist. No.

09997

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Adams	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 32 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS RFD 4	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First LAWRENCE Middle M. Last SHEADS		4. DATE OF DEATH Month September Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 23, 1895
9. AGE (In years lost birthday) yrs. 63		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inventory Control Clerk		10b. KIND OF BUSINESS OR INDUSTRY Book Company	
11. BIRTHPLACE (State or foreign country) Gettysburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Sheads		14. MOTHER'S MAIDEN NAME Sarah Wilhide	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW I- Yes 8/30/18-1/21/1919		16. SOCIAL SECURITY NO. 204-05-1452	
INFORMANT Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT LUNG 162.1 X METASTATIC CARCINOMA, RIGHT LUNG, MEDIASTINAL LYMPH NODES, LIVER, SKULL, LEFT 5TH RIB, 5TH LUMBAR VERTEBRA X BRONCHOPNEUMONIA (c) CARDIAC HYPERTROPHY AND MYOCARDIAL SCARRING		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN RECENT UNKNOWN
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, MARKED, GENERALIZED. CEREBRAL CONGESTION & EDEMA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that X attended the deceased from August 14 , 19 59 , to September 15 , 19 59 , and that death occurred at 9:30 P. M, from the causes and on the date stated above.		DATE SIGNED 9/16/59
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH; BALTO 18, MD. FORT HOWARD DIVISION
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO 18, MD., FT. HOWARD DIV.

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 9-16-59	22c. NAME OF CEMETERY OR CREMATORY Gettysburg National Cem.	22d. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania.
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23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. 6009 Harford Rd.	ADDRESS Wm Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.	24a. REC'D BY REGISTRAR DATE SEP 18 59	24b. REGISTRAR'S SIGNATURE Arthur A. Thomas
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up by Bender Funeral - Home, Carlisle St., Gettysburg, Pa.

CERTIFICATE OF DEATH

10020

Full Name: [illegible]

Age: 32 days

Place of Birth: [illegible]

Sex: Male

Color: White

Birth Date: September 22, 1933

Place of Birth: [illegible]

Birth Date: [illegible]

Place of Birth: [illegible]

Birth Date: [illegible]

Place of Birth: [illegible]

Birth Date: [illegible]

Place of Birth: [illegible]

Birth Date: [illegible]

Place of Birth: [illegible]

Birth Date: [illegible]

Place of Birth: [illegible]

Birth Date: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10021

CERTIFICATE OF DEATH

Reg. Dist. No.

09998

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b 20	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7916 High Point Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle G. Last Sheckart		4. DATE OF DEATH Month Sept. Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1921
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Process Planner		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Sheckart		14. MOTHER'S MAIDEN NAME Jeannie LaBott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. # 2 072-12-5028	
17. INFORMANT Mrs. Mary Sheckart		Address 7916 High Point Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widely spread metastatic carcinoma 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Widely spread metastatic carcinoma DUE TO (c) 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to Sept. , 19 59 , that I last saw the deceased alive on Sept. 27 , 19 59 , and that death occurred at 12 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William H. Jones		ADDRESS (Street, city or town, state) DATE SIGNED 5100 Harford Rd., Balto. Md. 10/1/59	
PHYSICIAN'S NAME (Type) L. H. Jones			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		22d. LOCATION (City, town, or county) (State) Trump Mill Rd. Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. H. Jones		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE OCT 2 1959		24b. REGISTRAR'S SIGNATURE W. H. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10022

CERTIFICATE OF DEATH

Reg. Dist. No.

09999

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle L. Last SHUGARS		4. DATE OF DEATH Month September Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1919
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Shugars		14. MOTHER'S MAIDEN NAME Jane Suthers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 218-05-2944	
INFORMANT Clin. Records VAH, Balto 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS (c) ATHEROSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Infarction			
INTERVAL BETWEEN ONSET AND DEATH 16 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from September 8, 1959 , to September 24, 1959 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) VAH Balto., Md. Ft. Howard Div. DATE SIGNED 9/24/59	
PHYSICIAN'S NAME (Type) JAMES R. POWDER, M.D.		VAH Balto., Md. Ft. Howard Div. 9/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR SEP 29 '59 DATE SEP 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

WM. COOK-BLIGHT, INC. 6009 HARFORD RD., BALTO., MD.

10023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>611 Alleghany av</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA CLEMENTINE Smith</u> First Middle Last		4. DATE OF DEATH <u>Sept 2 1959</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 15 1881</u>
9. AGE (If years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Easton Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert M Larimore</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Dorothy Smith Schloss Stevenson</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.3 Pneumonia</u> DUE TO (b) <u>Metastatic carcinomatosis</u> DUE TO (c) <u>Malignant papilloma of sigmoid (removed October 5, 1957)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>2 years</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis HCVD Malnutrition</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 16</u> , 19 <u>55</u> , to <u>September 2</u> 19 <u>59</u> , that I last saw the deceased alive on <u>September 2</u> , 19 <u>59</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>18 West Tager Street Baltimore 2, Maryland</u> DATE SIGNED <u>9/3/59</u>			
ACTUAL SIGNATURE <u>B. H. Rutledge</u> M.D.			
PHYSICIAN'S NAME (Type) <u>B. H. Rutledge, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Jenkins & Sons Co 4905 York</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MONKTON		c. LENGTH OF STAY IN 1b MONKTON, MD. BALTO 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BLUE RIDGE RD.		d. STREET ADDRESS BLVD 3519 HICKORY AVE	
3. NAME OF DECEASED (Type or print) First Edgar Middle John Last Smith		4. DATE OF DEATH Month Sept. Day 4 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 25 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SWITCH BOARD OPERATOR UNIVERSITY APT.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MCCLELLIAN SMITH		14. MOTHER'S MAIDEN NAME ANNA NEAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. WM SMITH - 3437 ASH ST.	
17. INFORMANT WM SMITH - 3437 ASH ST.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardio Vascular disease 1422.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2/59 , 19____, to 9/4/59 , 19____, that I last saw the deceased alive on 9/2/59 , 19____, and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) PARKTON, MD. DATE SIGNED 9/5/59			
ACTUAL SIGNATURE A. M. France		PHYSICIAN'S NAME (Type) A. M. FRANCE	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/7/59	
22c. NAME OF CEMETERY OR CREMATORY MORGAN CHAPEL		22d. LOCATION (City, town, or county) (State) CARROLL CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS 3818 Roland Ave		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Physician

Attending Physician

Signature

Official Seal

09906

CERTIFICATE OF DEATH

Reg. Dist. No.

10062

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1249 Francis Ave.				d. STREET ADDRESS 1 1249 Francis Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nels Middle Smith Last Smith				4. DATE OF DEATH Month Sept. Day 18, Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1889	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? unknown	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Army Ordnance Dept.			
13. FATHER'S NAME Anders Smith				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mr. Edwin A. Smith - 1249 Francis Ave., Halethorpe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO (b) PULMONARY EMBOLISM DUE TO (c) CLARENCE CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/1 , 19 59 to 9/18 , 19 59 , that I last saw the deceased alive on 9/17 , 19 59 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1249 Francis Ave., Halethorpe, Md. DATE SIGNED 9/18/59							
ACTUAL SIGNATURE John H. Shaw M.D.				PHYSICIAN'S NAME (Type) John H. Shaw			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/19/59			
22c. NAME OF CEMETERY OR CREMATORY Alpine Cem.				22d. LOCATION (City, town, or county) (State) Perth Amboy, N.J.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Trakner & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE SEP 21 '59			
24b. REGISTRAR'S SIGNATURE William E. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. Page 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3

VS A15 (4)

ISM 9/58

30287



10025 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 21 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle P. Last SNELLING				4. DATE OF DEATH Month September Day 2 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1892	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Palmer G. Snelling				14. MOTHER'S MAIDEN NAME Anna Smullen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-03-4451		INFORMANT Address Clin. Rec. VAH, Balto 18, Md., Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMOPTYSIS 162.1 DUE TO BRONCHOGENIC CARCINOMA, RIGHT LOWER LOBE (b) METASTATIC CARCINOMA, LUNG, MEDIASTINAL LYMPH NODES, (c) PULMONARY INFARCTS, MULTIPLE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. VENOUS INFARCTS, LIVER, RECENT. ATROPHY, ADRENALS UNKNOWN DURATION						INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN RECENT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 12 , 19 59 , to Sept. 2 , 19 59 , and that death occurred at 4:50p AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford				ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD FORT HOWARD DIVISION 9/3/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/59		22c. NAME OF CEMETERY OR CREMATORY Allen Meth. Church Cem/		22d. LOCATION (City, town, or county) (State) Allen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Funeral Home				24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1. TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Deceased: [Name] Date of Death: [Date]

Age: [Age] Sex: [Sex] Race: [Race]

Place of Birth: [Place]

Occupation: [Occupation]

Marital Status: [Status]

Signature of Physician: [Signature]

Signature of Registrar: [Signature]

Witness: [Name]

Medical History: [Text]

Cause of Death: [Text]

Time of Death: [Time]

Place of Death: [Place]

Signature of Deceased: [Signature]

Signature of Next of Kin: [Signature]

Signature of Burial: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10026

CERTIFICATE OF DEATH

10004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forrest Haven</u>		d. STREET ADDRESS <u>1709 Summit Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Morgan P. Stallings</u>		4. DATE OF DEATH Month Day Year <u>September 2 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1870</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Robertson Oil Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-12-7054</u>	
17. INFORMANT <u>Lauroy Brown</u>		Address <u>1709 Summit Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CHANGES</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>CIRCULATORY DISEASE</u> (c) <u>PERIPHERAL CIRCULATORY COLLAPSE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/12</u> , 19 <u>59</u> , to <u>9/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/14</u> , 19 <u>59</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John A. Shaw</u> M.D.		5800 EDMONSON AVE	
PHYSICIAN'S NAME (Type) <u>JOHN A. SHAW M.D.</u>		<u>HALE 28, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Savage, Howard Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Imbros, Inc. 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10005

10027

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Conv. Home</u>				d. STREET ADDRESS <u>Vernon Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Bohn Standiford</u>				4. DATE OF DEATH Month Day Year <u>September 26 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Saylor Bohn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Burrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>59</u> , to <u>9/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>59</u> , and that death occurred at <u>1:40 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Franke</u> M.D.				ADDRESS (Street, city or town, state) <u>PARKTON, MD.</u> DATE SIGNED <u>9/28/59</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANKE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 29 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Reg. Dist. No.

10028

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b X Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2001 Monumental Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle M. Last Steinberg				4. DATE OF DEATH Month Sept. Day 8, Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11'18'1886	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William J. Beatley				14. MOTHER'S MAIDEN NAME Mary Dickey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Mrs. F.A. Schmidt		Address 2001 Monumental Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 174X IMMEDIATE CAUSE (a) Emaciation & Congestive Failure DUE TO Carcinoma of uterus gave rise to immediate cause (a), stating the underlying cause last. DUE TO with multiple metastasis (abdominal) (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 59 at 9/8 , 19 59 that I last saw the deceased alive on 9/8 , 19 59 , and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>James Frederick</i>		M.D. 1305 Francis Avenue #27					
PHYSICIAN'S NAME (Type) James Frederick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9'11'59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR SEP 11 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Howard H. Hubbard 4107 Wilkins Avenue

Burial 011152 Loudon Park Cemetery, Baltimore, Maryland

James Frederick 1505 Francis Avenue #27

no

none

Mrs. F.A. Schmidt

2001 Monumental Ave

William J. Bentley

Mary Dickie

housewife

Maryland

U. S. A.

female

white

11/18/1886

72

Scalpers

Sept. 8,

2001 Monumental Avenue

2001 Monumental Avenue

Baltimore

Baltimore

Baltimore

Maryland

Baltimore

CERTIFICATE OF DEATH

0022

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should not be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10029

CERTIFICATE OF DEATH

10007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex 21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>315 Savannah Ave</u>		d. STREET ADDRESS <u>315 Savannah Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Gallay</u>		4. DATE OF DEATH <u>Sept 12 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 18-1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bullock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>28301341</u>	
17. INFORMANT <u>Joseph Gallay</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart failure, chronic</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>5 years</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 9, 1959</u> to <u>July 8, 1959</u> , that I last saw the deceased alive on <u>July 8, 1959</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene C. Baumann</u>		ADDRESS (Street, city or town, state) <u>413 Eastern Ave Baltimore 21, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann</u>		DATE SIGNED <u>9-13-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cemetery Essex 21 Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Bagginski</u>		ADDRESS <u>1407 Eastern Ave</u>	
24a. REC'D BY REGISTRAR <u>SEP 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	

CERTIFICATE OF DEATH

1952

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "Jan 15, 1907"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE [Faint text, possibly "June 10, 1930"]</p>	
<p>9. CAUSE OF DEATH [Faint text, possibly "Heart disease"]</p>		<p>10. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>11. DATE OF DEATH [Faint text, possibly "Dec 10, 1952"]</p>		<p>12. TIME OF DEATH [Faint text, possibly "10:30 AM"]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>14. SIGNATURE OF REGISTRAR [Faint signature]</p>	

LAM BOND
 PATENTED
 1900

THIS CERTIFICATE IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR ALTERED IN ANY MANNER WITHOUT THE WRITTEN ORDER OF THE COMMISSIONER OF HEALTH.

10030

CERTIFICATE OF DEATH

10008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1506 Dornton Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>P.</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1925</u>
9. AGE (In years lost birthday) yrs. <u>33</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.T.&T. Tele. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Bloxom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-20-9183</u>	
17. INFORMANT <u>Mrs. Phyllis M. Taylor</u>		Address <u>1506 Dornton Ave. 20</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>190.9</u> DUE TO <u>Metastatic CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignant Melanoma</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 23, 1959</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>701 EASTERN AVENUE BALTIMORE 21 Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>John E. Gessner</u> M.D. PHYSICIAN'S NAME (Type) <u>JOHN E. GESSNER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 25, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Downing's</u>		22d. LOCATION (City, town, or county) (State) <u>Oak Hill, Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>	
ADDRESS <u>7401 Belair Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10030

CERTIFICATE OF DEATH

10001

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME: *John Edward Smith*

DATE OF BIRTH: *March 15, 1915*

PLACE OF BIRTH: *Boston, Massachusetts*

DATE OF DEATH: *October 10, 1975*

PLACE OF DEATH: *Worcester, Massachusetts*

CAUSE OF DEATH: *Myocardial Infarction*

PERMANENT ADDRESS: *123 Main Street, Worcester, MA 01601*

SIGNATURE OF REGISTRAR: *[Signature]*

DATE: *October 15, 1975*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10009

Reg. Dist. No.

10031

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2mth27dys</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>E.</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Generalized arteriosclerosis</u> cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right femur</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell in bathroom sustaining fracture of right femur</u>					
20c. TIME OF INJURY Month, Day, Year <u>8-27-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Geo. M. Kieffer</u>		M.D. <u>George M. Kieffer, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-1-59</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>9.5.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Baeto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary - 130 E. Fort Ave.</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>DA SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Kinas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10032 CERTIFICATE OF DEATH

Reg. Dist. No.

10010

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4, Maryland		c. LENGTH OF STAY IN 1b 31 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1001 Malvern Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Bryant Last Tompkins		4. DATE OF DEATH Month September Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/06
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Osteopath		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Somerset, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Everett Tompkins		14. MOTHER'S MAIDEN NAME Emma Grace Bryant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 213-38-6296	
17. INFORMANT Son. St. R.D. Tompkins		Address 445 Sunset Pk. Novato, Calif.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastasis 190.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Subungual melanoma, left fifth toe DUE TO (c) 1 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced metastatic disease - melanoma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 17 , 19 59 , to Sept. 17 , 19 59 , that I last saw the deceased alive on Sept. 17 , 19 59 , and that death occurred at 4:55 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 E. Biddle St., Balto. 2, Md. DATE SIGNED 9/17/59 ACTUAL SIGNATURE Robert G. Chambers M.D. PHYSICIAN'S NAME (Type) Robert G. Chambers, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/21/59	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, INC - TOWSON, MD		24a. REC'D BY REGISTRAR SEP 21 1959	
24b. REGISTRAR'S SIGNATURE Arthur J. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10011

10033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7903 Ellenham Ave		d. STREET ADDRESS 7903 Ellenham Ave	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUST Middle FREDERICK Last TRUMPLER		4. DATE OF DEATH Month Sept. Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager -Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail Jewellery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Maximilliaon L. Trumpler		14. MOTHER'S MAIDEN NAME Susan L. Leutner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 216-01-2453	
17. INFORMANT Ruth J. Trumpler-7903 Ellenham Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12 , 19 56 , to Sept 18 , 19 59 , that I last saw the deceased alive on Sept 18 , 19 59 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 DATE SIGNED 9/19/59 ACTUAL SIGNATURE Laurence C. Post M.D. PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 22/59	
22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens		22d. LOCATION (City, town, or county) (State) Balto County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. Towson, Maryland		24a. REC'D BY REGISTRAR DATE SEP 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

CERTIFICATE OF DEATH

Reg. No. 100

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 37		4. DATE OF BIRTH Jan 19, 1928	
5. PLACE OF BIRTH Jackson, Tenn.		6. OCCUPATION Minister	
7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION High School		10. RELIGION Methodist	
11. PLACE OF DEATH Baltimore, Md.		12. CAUSE OF DEATH Heart Disease	
13. MANNER OF DEATH Natural		14. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
15. SIGNATURE OF REGISTRAR J. Edgar Hoover		16. SIGNATURE OF WITNESSES J. Edgar Hoover	
17. SIGNATURE OF DECEASED J. Edgar Hoover		18. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
19. SIGNATURE OF CLERGYMAN J. Edgar Hoover		20. SIGNATURE OF BURIAL OFFICIAL J. Edgar Hoover	
21. SIGNATURE OF FUNERAL HOME J. Edgar Hoover		22. SIGNATURE OF CEMETERY J. Edgar Hoover	
23. SIGNATURE OF CORONER J. Edgar Hoover		24. SIGNATURE OF JURY J. Edgar Hoover	
25. SIGNATURE OF JUDGE J. Edgar Hoover		26. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover	
27. SIGNATURE OF COUNTY CLERK J. Edgar Hoover		28. SIGNATURE OF STATE CLERK J. Edgar Hoover	
29. SIGNATURE OF SECRETARY OF HEALTH J. Edgar Hoover		30. SIGNATURE OF COMMISSIONER OF HEALTH J. Edgar Hoover	

37

ST 18
JAN 19 1965
J. Edgar Hoover

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10012
Item 18 Film 249 10-8-59 ams										
10034										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH Rosewood State Training School					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 16, Maryland					3V01-4
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School					d. STREET ADDRESS 2833 Presbury Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First Alisa Middle Ann Last Vaughns			4. DATE OF DEATH			Month SEPTEMBER Day 27 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/57			9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Vaughns					14. MOTHER'S MAIDEN NAME Ruth Bella Banks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. ---		INFORMANT Rosewood Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 344X DUE TO Aspiration of stomach contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. no external condition DUE TO no external condition (c) no external condition									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) External hydrocephalus									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 26, 1958 , to Sept 27, 1959 , that I last saw the deceased alive on 9/27/59 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE Edward J. Mathews M.D.					ADDRESS (Street, city or town, state) Rosewood State Training School Box 188 Owings Mills, Maryland					DATE SIGNED 9-27-59
PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D.										
22a. BURIAL, CREMATION, or REMOVAL (Specify)			22b. DATE THEREOF 9-30-59		22c. NAME OF CEMETERY OR CREMATORY Not Calvary Cem			22d. LOCATION (City, town, or county) (State) Baltimore, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilkins ADDRESS 1000 Brewster					24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE Anthony J. Thomas			

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10035
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inverness		c. LENGTH OF STAY IN 1b 24 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence, 102 Bayside Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Henry Vogel		4. DATE OF DEATH Sept. 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustav Vogel		14. MOTHER'S MAIDEN NAME Katherine Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Army & 1919 to 1936		16. SOCIAL SECURITY NO. 6213-07-5422	
17. INFORMANT Mrs. Henrietta Vogel		Address 102 Bayside Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardi-vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 11 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-19-59 to 9-23-59 , that I last saw the deceased alive on 9-22-59 , and that death occurred at 9:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M B Davis		ADDRESS (Street, city or town, state) 6800 MORNINGTON RD DUNDALK MD	
DATE SIGNED 9/24/59			
PHYSICIAN'S NAME (Type) Melvin B. Davis M.D.			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 9-26-1959	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR SEP 28 1959		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

c

10036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
c. LENGTH OF STAY IN 1b 81 years		d. STREET ADDRESS 430 Main Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 430 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Joseph Vondersmith		4. DATE OF DEATH Month Day Year September 17 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 19 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Balto Transit	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel S Vondersmith		14. MOTHER'S MAIDEN NAME Maria Louise Humpreys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-8652	
17. INFORMANT H J Vondersmith		Address Reisterstown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis - chronic decompensating (c) Hypertension - arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-39 to 11-17 , 19 59 , that I last saw the deceased alive on 10-17-59 , 19 59 , and that death occurred at 10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Saffell M.D.		ADDRESS (Street, city or town, state) Reisterstown Md	
DATE SIGNED 9-19-59			
PHYSICIAN'S NAME (Type) James C. Saffell		Reisterstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 21 1959	22c. NAME OF CEMETERY OR CREMATORY Reisterstown Meth Cem	22d. LOCATION (City, town, or county) (State) Reisterstown Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman & Sons		ADDRESS Reisterstown Md	
24a. REC'D BY REGISTRAR SEP 22 '59		24b. REGISTRAR'S SIGNATURE Caroline E. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of histologist		23. Signature of bacteriologist		24. Signature of virologist	
25. Signature of epidemiologist		26. Signature of public health nurse		27. Signature of health visitor	
28. Signature of school nurse		29. Signature of midwife		30. Signature of other health personnel	
31. Signature of other health personnel		32. Signature of other health personnel		33. Signature of other health personnel	
34. Signature of other health personnel		35. Signature of other health personnel		36. Signature of other health personnel	
37. Signature of other health personnel		38. Signature of other health personnel		39. Signature of other health personnel	
40. Signature of other health personnel		41. Signature of other health personnel		42. Signature of other health personnel	
43. Signature of other health personnel		44. Signature of other health personnel		45. Signature of other health personnel	
46. Signature of other health personnel		47. Signature of other health personnel		48. Signature of other health personnel	
49. Signature of other health personnel		50. Signature of other health personnel		51. Signature of other health personnel	
52. Signature of other health personnel		53. Signature of other health personnel		54. Signature of other health personnel	
55. Signature of other health personnel		56. Signature of other health personnel		57. Signature of other health personnel	
58. Signature of other health personnel		59. Signature of other health personnel		60. Signature of other health personnel	
61. Signature of other health personnel		62. Signature of other health personnel		63. Signature of other health personnel	
64. Signature of other health personnel		65. Signature of other health personnel		66. Signature of other health personnel	
67. Signature of other health personnel		68. Signature of other health personnel		69. Signature of other health personnel	
70. Signature of other health personnel		71. Signature of other health personnel		72. Signature of other health personnel	
73. Signature of other health personnel		74. Signature of other health personnel		75. Signature of other health personnel	
76. Signature of other health personnel		77. Signature of other health personnel		78. Signature of other health personnel	
79. Signature of other health personnel		80. Signature of other health personnel		81. Signature of other health personnel	
82. Signature of other health personnel		83. Signature of other health personnel		84. Signature of other health personnel	
85. Signature of other health personnel		86. Signature of other health personnel		87. Signature of other health personnel	
88. Signature of other health personnel		89. Signature of other health personnel		90. Signature of other health personnel	
91. Signature of other health personnel		92. Signature of other health personnel		93. Signature of other health personnel	
94. Signature of other health personnel		95. Signature of other health personnel		96. Signature of other health personnel	
97. Signature of other health personnel		98. Signature of other health personnel		99. Signature of other health personnel	
100. Signature of other health personnel		101. Signature of other health personnel		102. Signature of other health personnel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10037

CERTIFICATE OF DEATH

10015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 606 Stoneleigh Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MAYNARD Last WAGNER		4. DATE OF DEATH Month Sept. Day 3 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6, 1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Henry Wagner		14. MOTHER'S MAIDEN NAME Annie Elizabeth Knoblock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. C. Serena Wagner - 606 Stoneleigh Rd.		Address Balto. 12, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 15, 1959 to Sept 3, 1959 , that I last saw the deceased alive on Aug 29, 1959 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 W 29th St - Baltimore DATE SIGNED PHH			
ACTUAL SIGNATURE Norman R. Freeman, Jr.		PHYSICIAN'S NAME (Type) Norman R. Freeman, Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lickner & Sons - Balto. 7, Md.		ADDRESS	
24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Clifford E. Howard	

CERTIFICATE OF DEATH

1907

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>NAME OF DECEASED</p> <p>AGE</p> <p>SEX</p> <p>RACE</p> <p>DATE OF BIRTH</p> <p>DATE OF DEATH</p> <p>PLACE OF BIRTH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS OCCUPATION</p> <p>PREVIOUS HOBBIES</p> <p>PREVIOUS RELIGION</p> <p>PREVIOUS EDUCATION</p> <p>PREVIOUS MARRIAGE</p> <p>PREVIOUS CHILDREN</p> <p>PREVIOUS PARENTS</p> <p>PREVIOUS SIBLINGS</p> <p>PREVIOUS OTHER</p>		<p>DATE OF DEATH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS OCCUPATION</p> <p>PREVIOUS HOBBIES</p> <p>PREVIOUS RELIGION</p> <p>PREVIOUS EDUCATION</p> <p>PREVIOUS MARRIAGE</p> <p>PREVIOUS CHILDREN</p> <p>PREVIOUS PARENTS</p> <p>PREVIOUS SIBLINGS</p> <p>PREVIOUS OTHER</p>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Lansdowne 27 d. STREET ADDRESS 1 237 3rd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HIRAM Middle B. Last WAGNER		4. DATE OF DEATH Month September Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1892
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Samuel Wagner		14. MOTHER'S MAIDEN NAME Laura Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 705-05-2004	
17. INFORMANT Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 11, 1959 to September 20, 1959 and that death occurred at 11:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) VAH, BALTO, MD. FORT HOWARD DIVISION DATE SIGNED 9/21/59	
ACTUAL SIGNATURE David A. Oursler, M.D.		M.D. VAH, BALTO, MD. FORT HOWARD DIVISION	
PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D.		VAH, BALTO, MD. FORT HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WTTZKE Funeral Home, 4101 Edmondson Ave., Balto. Md.		24a. REC'D BY REGISTRAR SEP 22 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur A. Kline	

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10039

10017

10039

CERTIFICATE OF DEATH

Reg. Dist. No.

10017

10039

CERTIFICATE OF DEATH

Reg. Dist. No.

10017

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 2825 MAUDLIN AVE	
3. NAME OF DECEASED (Type or print) First ANNIE Middle ESTELLE Last WAIN		4. DATE OF DEATH Month SEPT Day 11 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1873
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME GEORGE E BASFORD		14. MOTHER'S MAIDEN NAME MAURA WREN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 422.1 DUE TO Vascular Disease - Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-17-49 , 19____, to 9-11 , 19 59 , that I last saw the deceased alive on 9-10 , 19 59 , and that death occurred at 12:53 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Kees		ADDRESS (Street, city or town, state) Cockeysville, Md.	
DATE SIGNED 9/11/59			
PHYSICIAN'S NAME (Type) Walter T. Kees		Cockeysville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-14-59	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Md
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
24b. REGISTRAR'S SIGNATURE Curtis & Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF HAIR Brown		9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. PLACE OF DEATH Baltimore, Md.		12. CAUSE OF DEATH Suicide		13. MANNER OF DEATH Homicide		14. MEDICAL HISTORY None		15. PREVIOUS ILLNESS None	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. DATE OF DEATH 12-1-68		22. TIME OF DEATH 10:00 AM		23. PLACE OF DEATH Baltimore, Md.		24. NAME OF HOSPITAL None		25. NAME OF PHYSICIAN J. Edgar Hoover	
26. NAME OF CORONER J. Edgar Hoover		27. NAME OF WITNESS J. Edgar Hoover		28. NAME OF DECEASED J. Edgar Hoover		29. NAME OF NEXT OF KIN J. Edgar Hoover		30. NAME OF PHYSICIAN J. Edgar Hoover	



10 HOBART ST. BALTIMORE, MD 21201

JO HOBART ST. BALTIMORE, MD 21201

10 HOBART ST. BALTIMORE, MD 21201

10040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE SHEPPARD AND ENOCH PRATT HOSPITAL			d. STREET ADDRESS 1520 Buchanan Street, N. W.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Frank Middle A. Last Walker			4. DATE OF DEATH Month September Day 14 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1872		9. AGE (In years last birthday) yrs. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Employee			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME James Vernon Walker			14. MOTHER'S MAIDEN NAME Susan Matilda Werninger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 7 yrs + 7 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Brain Syn. drome due to cerebral arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Washington, D. C.			(County) (State)		
21. I certify that I attended the deceased from Sept 17, 1953 to Sept 14, 1959 , that I last saw the deceased alive on Sept 12, 1959 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington, D. C. DATE SIGNED September 14, 1959					
ACTUAL SIGNATURE W. W. Elgin			M.D. September 14, 1959		
PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.			The Sheppard and Enoch Pratt Hospital Towson 4, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Kees Crematory	
22d. LOCATION (City, town, or county) Wash. D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Kees			ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR DATE SEP 17 '59
24b. REGISTRAR'S SIGNATURE Charles L. Kneiss					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

OR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0820

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		65		1880		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 N. Main St.		Retired		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
1945		10:15		10		15		00	
DAY OF DEATH		MONTH OF DEATH		YEAR OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
10		10		1945		10		15	
PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
Home		Natural		Heart Disease		Natural		Heart Disease	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
1945		10:15		10		15		00	
DAY OF DEATH		MONTH OF DEATH		YEAR OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
10		10		1945		10		15	
PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
Home		Natural		Heart Disease		Natural		Heart Disease	

INSTRUCTIONS
1
M
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10019

CERTIFICATE OF DEATH

10041

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore	MARYLAND	STATE MARYLAND	COUNTY BALTIMORE-Co
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Wilson	LENGTH OF STAY (In this place) 18 months	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL NEAR WOODLAWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital		STREET ADDRESS (If rural give location) 6912 WINDSOR MILL RD	
3. NAME OF DECEASED (First) (Middle) (Last) THEODORE WALL		4. DATE OF DEATH (Month) (Day) (Year) Sept 10 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED	8. DATE OF BIRTH 11/26/18
9. AGE last birthday 40 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 11. IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AMBULANCE DRIVER		10b. KIND OF BUSINESS OR INDUSTRY NEW JERSEY	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LESLIE A. WALL SR.		14. MOTHER'S MAIDEN NAME BESSIE DEPEW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-2673	
17. INFORMANT & ADDRESS Hospital Records Mt. Wilson State Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
002X IMMEDIATE CAUSE (A) PULMONARY TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 6 years	
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/13, 1958, to 9/10, 1959, that I last saw the deceased alive on 9/10, 1959, and that death occurred at 11:55 PM, from the causes and on the date stated above.			
SIGNATURE Wm. Newcomer		DATE SIGNED 11-55 PM	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 9/14/1959	
24. REC'D BY REGISTRAR SEP 14 '59		REGISTRAR'S SIGNATURE Ellsworth Armacost	
25. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hghts. Av	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10020

10042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr2mth19dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle E. Last Walter		4. DATE OF DEATH Month September Day 2 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Burk		14. MOTHER'S MAIDEN NAME Rachael Beckley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary abscesses 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal bronchopneumonia DUE TO (c) Senile brain disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 21 , 19 59 , to Sept. 2 , 19 59 , that I last saw the deceased alive on Sept. 2 , 19 59 , and that death occurred at 9:40p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 9-3-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59	
22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home Catonsville Md		ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Knead			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10021

10043

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>805 WOODROW AVE.</u>		d. STREET ADDRESS <u>805 WOODROW AVE</u>	
3. NAME OF DECEASED (Type or print) <u>WALTERS</u> First <u>AUGUSTA</u> Middle <u>Maria</u> Last <u>Gusta</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-99</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>? WILKINSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-9950</u>	
17. INFORMANT <u>STELLA SIMMONS</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9/16/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>418 Eastern Blvd.</u>	
24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	

Two for One. FilmG249 9-24-59 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10044

10022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lutherville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Ridgeway Road</u>	
3. NAME OF DECEASED (Type or print) <u>Weltie Edward Warner</u>		4. DATE OF DEATH <u>September 23, 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1892</u> 66 yrs.
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Route</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sunpapers</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Effran Warner</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Margaret Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>212-32-4298</u>	
17. INFORMANT <u>Mrs. Frances Warner</u>		Address <u>Lutherville, Md. Ridgeway Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9-25-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 26, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Newell</u>		24. REC'D BY REGISTRAR <u>OCT 5 '59</u>	
ADDRESS <u>Pikesville 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Frank A. Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 49 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1204 Whatcoat Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle --- Last WARREN		4. DATE OF DEATH Month September Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1896
9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Warrenton, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Warren		14. MOTHER'S MAIDEN NAME Carrie Drummond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE ESOPHAGUS 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 102X DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS, ARRESTED 194 1957		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X attended the deceased from July 15 , 19 59 , to Sept. 2 , 19 59 , and that death occurred at 4:50 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 9/3/59	
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTO. 18, MD. FORT HOWARD DIV.	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/4/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS 1808-10 N. Monroe St. Baltimore 17, Md.		24b. REGISTRAR'S SIGNATURE Charles E. Kinn	

SHIPPED TO: McGuire Funeral Home, 9th & Westminster Sts Washington, D.C.

CERTIFICATE OF DEATH

1908

Maryland

Baltimore

Baltimore

19 Days

Fort Howard

1204 Westmont Street

Veterans Administration Hospital

NOBLES

WABURN A

Male Colored

August 19, 1908

Garretts

Garretts

Washington, D.C.

Proctor's

Proctor's

Yon W I

Unknown

1111 1/2 Ave. N. W. Fort Howard Division

CARDINALS BY THE EPISCOPAL

UNKNOWN

FOR FURTHER INFORMATION, ADDRESS TO 1908

VI

July 18

Sept. 2

1908

Fort Howard, N.Y.

Fort Howard, N.Y.

Washington National Bank

General

10082

10082

Baltimore

Maryland

Baltimore

Woodlawn

Woodlawn

3308 Albany Avenue

3308 Albany Avenue

23

September

ELEANOR WILKINSON

ELEANOR WILKINSON

23

Nov. 14, 1935

Nov. 14, 1935

GBA

Maryland

Baltimore

Elizabeth Wallingford

Elizabeth Wallingford

215-02-8839 Marie Barbara Hines, 3303 Moody Ave.

Handwritten notes:
Faintly visible text, possibly "Faintly visible text" or similar.

Handwritten notes:
Faintly visible text, possibly "Faintly visible text" or similar.

Handwritten notes:
Faintly visible text, possibly "Faintly visible text" or similar.

Handwritten notes:
Faintly visible text, possibly "Faintly visible text" or similar.

Handwritten notes:
Faintly visible text, possibly "Faintly visible text" or similar.

Maryland

Baltimore

London Park Cemetery

Baltimore

215-02-8839 Marie Barbara Hines, 3303 Moody Ave.

CERTIFICATE OF DEATH

Reg. Dist. No.

10025

10047

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle W. Last WERNTZ		4. DATE OF DEATH Month September Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warrant Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Norristown, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Winfield Scott Werntz		14. MOTHER'S MAIDEN NAME Mary Brenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I WW II 219-26-4867	
17. INFORMANT Clin. Records, VAH Balto. 18, Md., Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERIPHERAL VASCULAR COLLAPSE & PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) GEN. ARTERIOSCLEROSIS, CHRONIC BRAIN SYNDROME, RIGHT HEMIPARESIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28 , 19 59 , to September 20 , 19 59 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Balto Md, Ft. Howard Div. 9/20/59			
ACTUAL SIGNATURE Harold R. Johnson		M.D. VAH Balto Md, Ft. Howard Div. 9/20/59	
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.		VAH Balto Md, Ft. Howard Div. 9/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF SEPT. 24. 59	22c. NAME OF CEMETERY OR CREMATORY Oaklam Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		24a. REC'D BY REGISTRAR SEP 24 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Frank			

HENRY SANDER & SONS, INC. NORTH AVE & BROADWAY, BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Place of Birth

Belgium

3307 1st Ave

September 20

August 22, 1883

Washington, D.C.

City of New York

212-23-1007 U.S. Census, Vol. 10, No. 11, New York

U.S. Census, Vol. 10, No. 11, New York

ADULT MALE, CAUCASIAN, INTERMEDIATE

DR. ANTHROPOLOGICAL, GROWING BRAIN SYNDROME, ADULT MALE

August 25, 1923

U.S. Census, Vol. 10, No. 11, New York

U.S. Census, Vol. 10, No. 11, New York

Washington, D.C.

City of New York

U.S. Census, Vol. 10, No. 11, New York

U.S. Census, Vol. 10, No. 11, New York

CERTIFICATE OF DEATH

Reg. Dist. No.

10026

10048

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 87 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17) d. STREET ADDRESS 2009 Clifton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ARTHUR Middle H. Last WHALEY			4. DATE OF DEATH Month September Day 24 Year 19 59		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1890		9. AGE (In years last birthday) 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Whaley			14. MOTHER'S MAIDEN NAME Mary Wooden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 200-14-8425	INFORMANT Clinical Records, VAH, Baltimore, Md. Fort Howard Address Division		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ABSCESSSES MULTIPLE, BILATERAL DUE TO (b) PULMONARY INFARCTS, INFECTED, MULTIPLE, BILATERAL DUE TO (c) MURAL THROMBOSIS, RIGHT AURICULAR APPENDAGE INTERVAL BETWEEN ONSET AND DEATH 6-8 WEEKS UNKNOWN UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, duration Unknown. Arteriosclerosis, marked, generalized, duration Unknown.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29 , 19 59 , to September 24, 1959 , and that death occurred at 7:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO., MD., FT. HOWARD DIVISION DATE SIGNED 9/25/59					
ACTUAL SIGNATURE <i>John W. Crawford</i>		M.D. VAH, BALTO., MD., FT. HOWARD DIVISION			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		ADDRESS 1808-10 N. Monroe St. Balto.		24a. REC'D BY REGISTRAR SEP 29 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur A. Thomas</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Maryland

Baltimore

(17) Baltimore

John Howard

2007 Madison Avenue

Veterans Administration Hospital

WOMAN

W

WHITE

June 2, 1960

Colored

Male

Baltimore, Maryland

John Howard

Indonesian

John Howard

John Howard

Yes

INDONESIA, BALI, KUTA, 1958

UNKNOWN

INDONESIA, BALI, KUTA, 1958

UNKNOWN

INDONESIA, BALI, KUTA, 1958

INDONESIA, BALI, KUTA, 1958

VA

29

June 19

1958

INDONESIA, BALI, KUTA, 1958

YAN, BALI, NO. 11, KUTAN DIVERIN

JOHN W. HOWARD, M.D.

Baltimore, Maryland

Indonesian

Indonesian, Bali, Kuta, 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10049

CERTIFICATE OF DEATH

Reg. Dist. No.

10027

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 24 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 133 WEST STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		0210-2	
3. NAME OF DECEASED (Type or print) First ISAAC		Middle WHIPPLE		Last WHIPPLE		4. DATE OF DEATH Month SEPT.		Day 10	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27 1890		9. AGE (In years last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME JAMES WHIPPLE		14. MOTHER'S MAIDEN NAME LACRA BROWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARCINOMA OF LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from 8/17 , 19 59 , to 9/10 , 19 59 , that I last saw the deceased alive on 9/10 , 19 59 , and that death occurred at 6:30 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland	
21. ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland		DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-59	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) Annapolis Md		22e. REGISTRAR'S SIGNATURE William Keese		22f. REGISTRAR'S SIGNATURE William Keese		22g. REGISTRAR'S SIGNATURE William Keese	
22h. REGISTRAR'S SIGNATURE William Keese		22i. REGISTRAR'S SIGNATURE William Keese		22j. REGISTRAR'S SIGNATURE William Keese		22k. REGISTRAR'S SIGNATURE William Keese		22l. REGISTRAR'S SIGNATURE William Keese	

CERTIFICATE OF DEATH

1933

Page 1 of 1

DATE OF DEATH

PLACE

DECEASED

DECEASED

AGE

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THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A CLERK OF A HOSPITAL OR A CLERK OF A COUNTY OR CITY HEALTH DEPARTMENT. IT IS NOT VALID IF SIGNED BY A CLERK OF A HOSPITAL OR A CLERK OF A COUNTY OR CITY HEALTH DEPARTMENT WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL SOCIETY.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10028

10059

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson,		c. LENGTH OF STAY IN 1b 7-8 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS Route 2, Box 345			
3. NAME OF DECEASED (Type or print) First Henry Middle Ishmeal Last White				4. DATE OF DEATH Month 9 Day 2 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/10/02	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME Lee White				14. MOTHER'S MAIDEN NAME Jeanette Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Maryland Mt. Wilson State Hospital records, Mt. Wilson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 102X Pulmonary tuberculosis and Coronary artery disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/3/59	
EXAMINER'S NAME (Type) D.D. Caples, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59		22c. NAME OF CEMETERY OR CREMATORY Beels Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Camp Springs Md	
23. FUNERAL DIRECTOR'S SIGNATURE Anthony Bros Funeral Home				ADDRESS 1661-600d Hope Rd SE WASH DC		24a. REC'D BY REGISTRAR DATE SEP 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

10051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 41 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle -- Last WHITE				4. DATE OF DEATH Month SEPTEMBER Day 30 Year 19 59			
5. SEX MALE		6. COLOR OR RACE COLOR		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1890	
9. AGE (In years lost birthday) 69 yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN		10b. KIND OF BUSINESS OR INDUSTRY SHIPPING		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MATTHEW WHITE		14. MOTHER'S MAIDEN NAME MARTHA BUSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 218-03-7347		INFORMANT CLIN REC VET ADM HOSP BALTIMORE MD		Address Ft Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA (RECENT) AND EMACIATION DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) METASTATIC ADENOCARCINOMA, LIVER AND URINARY BLADDER (c) ARTERIOSCLEROSIS, MARKED, GENERALIZED							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC HEMORRHAGIC CYSTITIS - Duration unknown Surgical agsence, lower colon. Colostomy							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 20 , 19 59 , to Sept. 30 , 19 59 , and that death occurred at 5:10 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford				DATE SIGNED VAH, BALTO. 18, MD. FORT HOWARD DIV. 10/1/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/59		22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		22d. LOCATION (City, town, or county) (State) Baltimore / Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				ADDRESS 1808-10 N. Monroe St. Balto. Md.		24a. REC'D BY REGISTRAR Arthur S. Kross	
24b. REGISTRAR'S SIGNATURE Arthur S. Kross				DATE OCT 6 59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• *Journal of the American Medical Association*, 1964; 190: 11-12.

Environ Biol Fish (2015) 98:103–113

1. *Journal of Management Studies*, 1991, 28, 1, 1-14.

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100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09907 Items 7, 22 Film G249 10-1-59 et

10030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5536 Selma Ave			d. STREET ADDRESS 5536 Selma Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Randall E. Middle White S. Last			4. DATE OF DEATH 9-26-59 Month 9 Day 26 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1910	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Cumberland Md	
13. FATHER'S NAME Sgt Ira White			14. MOTHER'S MAIDEN NAME Carrie (Unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218 07 4086		17. INFORMANT Ella White 5536 Selma Ave Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-29-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hubbard Funeral Home, 4107 Wilkins Ave.			24a. REC'D BY REGISTRAR DATE SEP 30 59		24b. REGISTRAR'S SIGNATURE <i>William J. Harris</i>

Balto. 29

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		POST-MORTEM EXAMINATION [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		DATE [Faint text]	
OFFICE OF THE MEDICAL EXAMINER [Faint text]		COUNTY [Faint text]	
STATE OF MARYLAND [Faint text]		CITY [Faint text]	

100

10052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN TB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3022 Rolling Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First R. Middle Milburn Last Widerman		4. DATE OF DEATH Month Sept. Day 17, Year 19 59	
5. SEX M.	6. COLOR OR RACE W.	7. ***** WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg.	
11. BIRTHPLACE (State or foreign country) Woodlawn, Balto. 7		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Widerman		14. MOTHER'S MAIDEN NAME Sally Ritter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) *****		16. SOCIAL SECURITY NO. 215-03-4348	
17. INFORMANT Miss Margaret E. Widerman		Address Balto. 7, Md. 3022 Rolling Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE GLAND WITH METASTASES 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 9 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****	20f. (City or town) (County) (State) *****
21. I certify that I attended the deceased from 19 49 to September , 19 59 , that I last saw the deceased alive on September 16, 19 59 , and that death occurred at 6:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/18/59			
ACTUAL SIGNATURE Millard T. Traband Jr. M.D.		PHYSICIAN'S NAME (Type) 5101 Gwynn Oak Ave, Balto. 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	22d. LOCATION (City, town, or county) (State) Randallstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		24a. REC'D BY REGISTRAR SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus
VS A15 (4) 15M 10/57		Randallstown, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100000

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		M		45		JAN 15 1900	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HARRIS		HEART DISEASE		NATURAL		100000	
RESIDENCE		OCCUPATION		EDUCATION		RELIGION	
BALTIMORE, MD.		CLOCK MAKER		HIGH SCHOOL		METHODIST	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1855		BALTIMORE, MD.		JAN 15 1880		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
JAMES H. HARRIS		MARY J. HARRIS		CLOCK MAKER		HOUSEWIFE	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FATHER'S EDUCATION		MOTHER'S EDUCATION	
BALTIMORE, MD.		BALTIMORE, MD.		HIGH SCHOOL		HIGH SCHOOL	
FATHER'S DEATH DATE		MOTHER'S DEATH DATE		FATHER'S DEATH PLACE		MOTHER'S DEATH PLACE	
JAN 15 1880		JAN 15 1880		BALTIMORE, MD.		BALTIMORE, MD.	
FATHER'S DEATH CAUSE		MOTHER'S DEATH CAUSE		FATHER'S DEATH MANNER		MOTHER'S DEATH MANNER	
HEART DISEASE		HEART DISEASE		NATURAL		NATURAL	
FATHER'S DEATH CERTIFICATE NO.		MOTHER'S DEATH CERTIFICATE NO.		FATHER'S DEATH CERTIFICATE NO.		MOTHER'S DEATH CERTIFICATE NO.	
100000		100000		100000		100000	
FATHER'S DEATH DATE		MOTHER'S DEATH DATE		FATHER'S DEATH PLACE		MOTHER'S DEATH PLACE	
JAN 15 1880		JAN 15 1880		BALTIMORE, MD.		BALTIMORE, MD.	
FATHER'S DEATH CAUSE		MOTHER'S DEATH CAUSE		FATHER'S DEATH MANNER		MOTHER'S DEATH MANNER	
HEART DISEASE		HEART DISEASE		NATURAL		NATURAL	
FATHER'S DEATH CERTIFICATE NO.		MOTHER'S DEATH CERTIFICATE NO.		FATHER'S DEATH CERTIFICATE NO.		MOTHER'S DEATH CERTIFICATE NO.	
100000		100000		100000		100000	

10053

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 W. BURKE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHRISTIAN Middle WILL Last WILL		4. DATE OF DEATH Month SEPTEMBER Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 24, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84	11. IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WILL		14. MOTHER'S MAIDEN NAME SOPHIE GARMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 14 hrs. 10 yrs. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2 , 1959, to Sept 11 , 1959, that I last saw the deceased alive on Sept. 11 , 1959, and that death occurred at 10:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5111 York Rd Baltimore Md DATE SIGNED Sept 11 1959			
ACTUAL SIGNATURE Carl F. Benson MD		PHYSICIAN'S NAME (Type) CARL F. BENSON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEM.		22d. LOCATION (City, town, or county) (State) TOWSON, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns, Sr., Towson, MD.		24a. REC'D BY REGISTRAR DATE SEP 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kears			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10054

CERTIFICATE OF DEATH

Reg. Dist. No.

10033

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jesse Nickles Williams				4. DATE OF DEATH Month Day Year 9-12-59 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-1877	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman				10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jake Williams				14. MOTHER'S MAIDEN NAME Stauffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ???			
17. INFORMANT Mrs. H. Benson Bareham,				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gen. Arteriosclerosis DUE TO (c) Carcinoma Stomach & Liver Metastases							INTERVAL BETWEEN ONSET AND DEATH 5 yrs ? 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 1954 to Sept. 12, 1959 , that I last saw the deceased alive on Sept. 12, 1959 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert H. Siver				ADDRESS (Street, city or town, state) 3105 N. Charles St. Baltimore, Md.			
PHYSICIAN'S NAME (Type) Robt. H. Siver				DATE SIGNED SEP 15 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-59		22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist		22d. LOCATION (City, town, or county) (State) Sparks, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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CERTIFICATE OF DEATH

Reg. Dist. No.

10034

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 Rogers Forge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 1 - 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Men's Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>Gardiff, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas J Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Parry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-09-0010</u>	
17. INFORMANT <u>Mrs Edna Williams</u>		Address <u>217 Rogers Forge Road Baltimore Md 12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>6 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 8, 1959</u> to <u>SEPT. 12, 1959</u> , that I last saw the deceased alive on <u>SEPT. 12, 1959</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur Karfquin</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ARTHUR KARFQUIN</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air HARTFORD Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>Bel Air Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE SIGNED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 82 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2016 ORLEANS STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle --- Last WILLIAMS		4. DATE OF DEATH Month SEPTEMBER Day 19 Year 19 59	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4 1888 9. AGE (In years lost birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACKMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) COLLINGTON MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS WILLIAMS		14. MOTHER'S MAIDEN NAME MARIA TYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 216-05-0991 INFORMANT CLIN REC VET ADM HOSP BALTIMORE MD Address Ft. Howard Division	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) PNEUMOTHORAX DUE TO (c) ESOPHAGEAL RESECTION FOR CARCINOMA OF ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH 1-1/2 HRS 5 DAYS 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from June 29 , 19 59 , to September 19 , 19 59 , and that death occurred at 6:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH BALTIMORE MD-FT HOWARD DIVISION DATE SIGNED 9-19-59			
ACTUAL SIGNATURE Daniel R. Zoll M.D. VAH BALTIMORE MD-FT HOWARD DIVISION		PHYSICIAN'S NAME (Type) DANIEL R. ZOLL MD VAH BALTIMORE MD-FT HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-23-59	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson Funeral Home		24a. REC'D BY REGISTRAR SEP 21 '59 24b. REGISTRAR'S SIGNATURE Elroy O Wilson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUFUS Middle -- Last WILLIAMS JR		4. DATE OF DEATH Month September Day 30 Year 19 59	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 10, 1928
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY BUSINESS SCHOOL	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUFUS WILLIAMS SR		14. MOTHER'S MAIDEN NAME LEOLIA BRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. PL-28 Korean 214-24-2439	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA AND PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CHRONIC GLOMERULONEPHRITIS (c) HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 21, 19 59 , to September 30, 19 59 , and that death occurred at 6:22 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FORT HOWARD DIV. DATE SIGNED 10/1/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/59	
22c. NAME OF CEMETERY OR CREMATORY Mount Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arington S. Phillips		24a. REC'D BY REGISTRAR OCT 6 '59	
ADDRESS 1808-10 N. Monroe St. Balto. Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(16)

DECEASED

DATE

TIME

3510 INMAN AVENUE

INMAN AVENUE

September 30

WILLIAMS JR

WHITE

September 30, 1954

WHITE

U.S.A.

WILLIAMS JR

WHITE

WILLIAMS JR

WHITE

THIS DEATH WAS REPORTED BY WILLIAMS JR TO THE DIVISION

REPORT

WILLIAMS JR

REPORT

WILLIAMS JR

REPORT

WILLIAMS JR

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September 30, 1954

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1954

WILLIAMS JR, 3510 INMAN AVENUE

WILLIAMS JR, 3510 INMAN AVENUE

WILLIAMS JR, 3510 INMAN AVENUE

WILLIAMS JR, 3510 INMAN AVENUE

WILLIAMS JR, 3510 INMAN AVENUE

WILLIAMS JR, 3510 INMAN AVENUE

10058

CERTIFICATE OF DEATH

10037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville 4</u>		c. LENGTH OF STAY IN 1b <u>3 yrs. 70 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Home for Aged</u>		d. STREET ADDRESS <u>Stevenson, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First <u>Wilson</u> Middle Last		4. DATE OF DEATH <u>Sept-9-1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1864</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phila. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Joseph Donahue</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Donahue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Charles A. Wilson, Jr.</u>		Address <u>Maryland Stevenson Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Breast - pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>lying cause lost.</u> (b) <u>gout arthritis - sclerosis</u> (c) <u>20 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>36</u> , to <u>Sept 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>59</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1725 Reisterstown Rd. Pikes. 8 Md.</u> DATE SIGNED <u>Sept 9-59</u>			
ACTUAL SIGNATURE <u>Palmer Williams</u>		M.D. <u>1725 Reisterstown Road, Pikesville 8 Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Palmer Williams, M.D.</u>		<u>1725 Reisterstown Road, Pikesville 8</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Bala-Cynwid, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS <u>Pikesville</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

[Faint, illegible handwritten notes and markings are visible across the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10038

10059

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Woodlawn d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 7007 Windsor Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY SIMPERS TIMANUS WINDSOR		4. DATE OF DEATH Month Day Year September 28 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Woodlawn, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Mary George Timanus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charlotte W. Tyson		Address Boston Landing Rd. Morristown, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8/59 , 19, to 9/28/59 , 19, that I last saw the deceased alive on 9/27/59 , 19, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd DATE SIGNED ACTUAL SIGNATURE Milton Schlenoff M.D. 6410 Windsor Mill Rd PHYSICIAN'S NAME (Type) Milton Schlenoff M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR Oct 1 '59 24b. REGISTRAR'S SIGNATURE Arthur J. Kline	

CERTIFICATE OF DEATH

10052

Baltimore

Maryland

Baltimore

Catonsville

Woodlawn

Grady Neek Nursing Home

1007 S. Edgar Mill Road

MARY SIMPSON TIMOTHY WIMBOR

September 20

Female White

Oct. 22, 1978

At home

Woodlawn, Maryland

USA

Mary George Timmons

None

Mrs. Charlotte W. Tyson-Montgomery, N.Y.
Barnes Landing Rd.

Card on file, District

in file of District

10/11/80

Dr. Olive Gossamer

10/11/80

Baltimore, Maryland

Elizabethtown, 1000 Liberty Avenue, N.Y. 10018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10060

CERTIFICATE OF DEATH

10039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residencia before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>56 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSP</u>			d. STREET ADDRESS <u>1231 W. LOMBARD ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MIHEL (Mikol) ZEPRESKO</u>			4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 12 1881</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler maker B. & O. R.R.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>HOSPITAL'S RECORDS</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstructive hydronephrosis</u> DUE TO (c) <u>Carcinoma of Prostate with regional metastases</u>					INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>weeks</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Sept. 4</u> , 19 <u>59</u> , to <u>Sept. 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 6</u> , 19 <u>59</u> , and that death occurred at <u>10:35 p. m.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Stella Wachler</u>		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>9/7/59</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		<u>M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) <u>4300 Old Frederick Rd.</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowardson</u>			ADDRESS <u>Balto., Md.</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Collins & King</u>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any changes are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Film 250 10-2 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10040											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 531 Eastern Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Peter Ziarnowski				4. DATE OF DEATH Month Sept. Day 26, Year 1959							
5. SEX M		6. COLOR OR RACE wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apri. 29, 1916		9. AGE (In years last birthday) 40 43rs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Ziarnowski						14. MOTHER'S MAIDEN NAME Antoinette Schultz					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 2				16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Theodore Ziarnowski-1005 W. Baltimore St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Sept. 27, 1959			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/26/1959		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or country) (State) Baltimore Maryland			
23. FUNERAL DIRECTOR'S NAME (Type) Ellsworth Armacost ADDRESS Ellsworth Armacost-4600 Liberty Heights Ave.						24a. REC'D BY REGISTRAR OCT 5 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			



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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10041

Reg. Dist. No.

10061

1. PLACE OF DEATH a. COUNTY <u>Parkton, Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto., Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Road</u>				d. STREET ADDRESS <u>York Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE ELIZABETH ZINN</u>				4. DATE OF DEATH Month Day Year <u>SEP. 15 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Marietta Donehew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES <input type="checkbox"/> NO <input type="checkbox"/>		16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Henry D. Scarberry</u> Address <u>York Rd., Parkton</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u>				DATE SIGNED <u>9/15/59</u>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Alto Baptist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Mount Alto W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brook's Funeral Service</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22		c. LENGTH OF STAY IN 1b 55 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6812 YOUNGSTOWN AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STANISLAUS ZOMKOWSKI		4. DATE OF DEATH SEPTEMBER 26, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 30, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER		10b. KIND OF BUSINESS OR INDUSTRY WEISKITTEL	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS ZOMKOWSKI		14. MOTHER'S MAIDEN NAME MARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-16-5388	
17. INFORMANT MR. BOLES LAUS ZOMKOWSKI		Address 1107 DUNDALK AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO 10 YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT. 9, 1957 to 9/26, 1959 , that I last saw the deceased alive on 9/26, 1959 , and that death occurred at 9:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. E. Baermann M.D.		DR. W. E. BAERMANN 3401 Dundalk Avenue Dundalk 22, Maryland	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 1, 1959	22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Kacprowski		24a. REC'D BY REGISTRAR OCT 6 '59	
ADDRESS 2525 FLEET ST.		24b. REGISTRAR'S SIGNATURE Charles J. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10092

CERTIFICATE OF DEATH

10092

BALTIMORE

DATE WHITE M. W. OCT 30 1895

PLACE OF BIRTH POLAND

FRANCIS J. JANKOWSKI

25 1/2

10092

10092

DATE OCT 1 1895

10092